A STUDY TO DETERMINE PERCEIVED AND ACTUAL KNOWLEDGE OF CAPE TOWN EMERGENCY MEDICAL CARE PROVIDERS WITH REGARD TO CHILD ABUSE

by

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DECLARATION

I, **Bruna Dessena**, hereby declare that the work on which this dissertation is based is my original work (except where acknowledgements indicate otherwise) and that neither the whole work nor any part has been, is being or is to be submitted for another degree in this or any other university.

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ABSTRACT

Aim: The aim of this study is to determine the level of perceived and actual knowledge of Cape Town emergency care personnel when dealing with children who acutely disclose incidents of sexual abuse.

Method: Operational EMS personnel and emergency medicine registrars in emergency centres located in the Cape Town metropolitan area were asked to complete a quantitative questionnaire with an optional qualitative portion. Informed consent was obtained and the participants' anonymity was guaranteed. A total of 120 voluntary participants – made up of 30 doctors, 30 Advanced Life Support personnel, 30 Intermediate Life Support personnel and 30 Basic Life Support personnel – took part in the study.

Findings: This study reveals that EMS personnel and emergency medicine registrars believe that they are inadequately trained and equipped to deal with situations in which a child discloses abuse. They remain capable of treating physical injuries but feel inadequate, frustrated and helpless when confronted by incidents of child abuse. The current EMS syllabus (with particular reference to its teaching and application in the Western Cape metropolitan area) is limited in the coverage of this subject. The syllabus only addresses types of abuse and how to treat the physical injuries relating to abuse, leaving many gaps in the knowledge of medical personnel.

With specific reference to sexual abuse, there is a paucity of information in the syllabus relating to how children who disclose their experiences of abuse should be managed. The current training syllabus does not include any information that could lead to an understanding of disclosure, the manner in which it evolves, why children are not always forthcoming with disclosure and more importantly, what to say to children when they disclose abuse.

Conclusion: When EMS personnel are called to a scene of child abuse they are uniquely positioned to make a significant difference in the initial intervention and management. The

first person the child encounters directly after the abuse is frequently an EMS member. This person is afforded a unique opportunity to observe the behaviour of the victim as well as that of the child's caregivers. They are also able to corroborate the mechanism of injury and verify aspects of the story as given to them by the caregivers, thus being more easily able to identify situations of suspected child abuse. More comprehensive training is required to enable EMS members to effectively and confidently deal with cases involving suspected or confirmed child abuse as well as disclosures of abuse by the patient.

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LIST OF ABBREVIATIONS

ALS	Advanced Life Support
BLS	Basic Life Support
CPD	Continuing Professional Development
CSA	Child Sexual Abuse
EC	Emergency Centre
EMS	Emergency Services
HPCSA	Health Professions Council of South Africa
ILS	Intermediate Life Support
OCD	Obsessive Compulsive Disorder
PTSD	Post Traumatic Stress Disorder
SAPS	South African Police Services

CHAPTER 1: INTRODUCTION

1.1 Background

During the two-year period of 2010–2011, 54 225 crimes against children were reported in South Africa. Half of these reported crimes were sexual offences, of which 30% related to children under the age of ten years. Since crimes against children are grossly under-reported, the true statistics on crimes against children in South Africa are unknown[1].

In the aftermath of abuse, the first person encountered by the abused child is frequently a member of the Emergency Medical Services (EMS). These personnel could range from the initial responders to the scene such as paramedics and ambulance staff, to doctors and registrars encountered at Emergency Centres (EC). In the event that a child chooses to disclose abuse, these individuals are uniquely positioned to handle this disclosure in an appropriate manner.

By definition, disclosure is the act of making new or secret information known and the child's disclosure will therefore involve the revelation of previously withheld information relating to his or her abuse. It must be noted however that non-disclosure does not indicate the absence of abuse, as each child processes trauma differently. The ability to process trauma is dependent on the child's age, cognition and ability to process the situation. A child's disclosure of abuse should attract urgent attention and should ideally be addressed on multiple levels by healthcare professionals, law enforcement officials, social workers and the child's immediate family.

The revelation of emotive, previously withheld information of this nature can trigger a ripple effect. Its disclosure necessitates the involvement of multiple professionals on different levels in the quest for protection and justice for the child. It is vital that EMS personnel be equipped to deal with every aspect of the disclosure. When treating a victim of child abuse, which affects physical as well as psychological functioning, they must consider the patient holistically. It is also important that EMS personnel reach a point where they are as

comfortable dealing with disclosures of this nature as they are with treating physical injuries and medical emergencies.

Although the scope of services provided by EMS personnel is diverse, for the purposes of this study the focus is on registrars working at government hospitals in ECs as well as emergency-care personnel employed in the Western Cape Emergency Services. These medical professionals are trained to attend to any medical emergency. The nature of their work requires both time-critical decision-making and emergency-care management in a high-stress environment.

The Cape Town metropolitan area, which is located to the south of the Western Cape, is serviced by Cape Town emergency-care providers in ambulances and response cars that cover an area of 2 479 km^2. Ambulance personnel work in pairs, functioning as Basic Life Support (BLS) or Intermediate Life Support (ILS) personnel. Advanced Life Support (ALS) paramedics often work alone in a response vehicle and are called upon if advanced emergency care is required until an ambulance arrives to transport the patient to hospital. The government-operated Metro Ambulance Services currently employs 2 083 ambulance personnel, of whom 1 702 are operational in Cape Town. (This excludes call-takers in the control centre and educators at the training college.)

Emergency medical personnel are required to work 12-hour shifts. This translates into 15 shifts per month. Basic and intermediate medics do the bulk of the work. A busy shift may entail a minimum of ten call-outs. In addition, the ambulance must be restocked and cleaned between calls. ALS paramedics, who provide further support services to basic and intermediate medics, attend to an average of seven call-outs per shift. Registrars in the ECs work 60 hours per week. The paramedics on duty hand over all patients whom they treat during their shift to these registrars.

Although time can be a limiting factor for these professionals, the use of standardised protocols when dealing with cases of child abuse can help reduce the confusion and stress experienced by personnel.

Research has shown that there are currently no guidelines or recommendations on the subject of disclosure, non-disclosure or even the process of disclosure available to the emergency medical personnel of government and emergency services in the Western Cape.

Despite the availability of numerous guidelines and standards pertaining to initial disclosure across the globe (including publications by the American Academy of Child and Adolescent Psychiatry), no universally accepted interview model has been developed for dealing with situations of child sexual abuse (CSA). Interview techniques differ greatly. However, there is a consensus on certain essential factors that facilitate disclosure, including what to say and how to respond as well as the use of open-ended, non-judgmental questions in an environment that is perceived as safe by the abused child[2].

The curriculum that is currently being taught in the Western Cape metropolitan area at the Western Cape Metro EMS College and the School of Emergency Medicine at the University of Cape Town ensures that EMS personnel are well equipped to deal with any type of trauma or medical emergency. The scope of practice includes intensive training in technical procedures and dosages as well as the use of life-saving equipment. However, training excludes the psychological aspects of child abuse, focusing instead on the identification of the physical signs and symptoms of abuse in the child (Appendices A, B & C). This suggests that practical skills that are required of EMS personnel in these situations (for example, reading body language, communicating in a non-threatening manner and listening) are being neglected.

Medical personnel should be familiar with the entire spectrum of child abuse, including emotional abuse. EMS personnel need to understand the psychological condition of an abused child in order to identify potential abuse and to facilitate disclosure in a safe environment.

Early identification and treatment of abuse expedites healing. In addition, it is important for emergency-care providers, who often have to liaise with the relevant authorities, to understand the disclosure process in order to facilitate the emotional healing of CSA victims. Considering the high prevalence of child abuse and the number of cases reported daily, it is

vital that this knowledge gap be addressed urgently. Therefore, we undertook a study to determine where these knowledge gaps lay and whether EMS Personnel felt equipped through their training to deal with child abuse disclosures and the more psycho-emotional aspects of responding to a child who is disclosing abuse. Ultimately, the goal would be to teach EMS personnel to be as confident with the psycho-emotional aspects of these interactions as they are comfortable with treating the physical injuries.

1.2 Aim and objectives

The aim of this research is to determine the perceived and actual knowledge levels of emergency-care providers relating to the legal, administrative and care procedures used in cases of child abuse.

The objectives of the research were:

- To establish the degree to which emergency-care providers felt equipped to deal with cases of child abuse in terms of the training they have received.
- To determine the knowledge that emergency-care providers have in terms of legal, administrative and care procedures when dealing with child abuse.
- To determine the discrepancy between perceived knowledge and actual knowledge when dealing with cases of child abuse
- To assess how the current curriculums teaching this subject are preparing the EMS personnel.
- To make recommendations to EMS services and management on best practice guidelines when dealing with child abuse cases.
- To make recommendations to all EMS colleges and training institutions for the inclusion of a Child Abuse Disclosure training module in the standard course of training.

CHAPTER 2: LITERATURE REVIEW

2.1 History

The earliest recorded case of child abuse dates back to the early Romano-Christian period. The skeleton of a toddler who had been subjected to gross physical abuse was found in the Dakhleh Oasis, Egypt, in 2013. The bones of the skeleton had multiple fractures with evidence of various degrees of healing[3].

Little scientific attention was paid to the subject of child abuse before 1946. It was then that Dr John Caffey, a well-known American paediatric radiologist, observed that numerous paediatric patients at his unit were presenting with a cluster of unexplained symptoms, including retinal haemorrhages, small subdural bleeds and intracranial haemorrhaging without external skull trauma. He coined the phrase “whiplash shaken infant syndrome” (subsequently replaced with the term “shaken baby syndrome”)[4]. These phenomena prompted emergency personnel to be more vigilant in looking for signs of possible child abuse.

However, the topic of child abuse remained limited to case reports until more detailed scientific studies could emerge. A group of paediatric nurses trained caregivers on various aspects of child interaction, including child discipline. The focus groups included first-time mothers and teenage mothers from low socio-economic backgrounds. Antenatal training sessions were supplemented by postnatal visits that were designed to assess the interaction of the mothers with their babies. The study aimed, via observation, to describe the interaction of participants with their infants and to identify any possible developmental issues.

The study concluded that mothers who were visited by the nurses during the first two years of their children’s lives presented with fewer reported cases of neglect and child abuse. It became evident that these mothers chose better toys for their toddlers, spent more time interacting and playing with their children, and punished them less severely than did

mothers who had not been trained by the nurses. The number of EC visits for children of the trained mothers dropped substantially when compared to those that had not received antenatal training sessions [5].

The current curriculum focuses on teaching medical personnel to identify visible signs of abuse. However, in highlighting the physical aspects of abuse, this training may lead to professionals overlooking non-verbal cues of abuse. The current curriculum also reinforces the notion that medical personnel are not required to deal with the non-physical trauma (psychological and emotional trauma) that accompanies child abuse.

A study by Allagia, a specialist in the field of children's mental health at the University of Toronto, focused on the various ways in which children disclosed abuse. She posits that disclosure by a child is markedly different from an adult "telling" another adult about an experience of abuse. The study classifies the style of disclosure of abuse as either formal or informal. These classifications are further refined into purposeful and prompted disclosure. Other subtypes of disclosure are described below.

A victim who makes a conscious decision to share information discloses purposefully, whereas a victim who is encouraged to disclose information during a medical examination or therapy session, or when questioned by the police, a social worker or a doctor is prompted to disclose.

Behavioural disclosure refers to a victim who wishes to disclose abuse but is unable to articulate the abuse and therefore displays non-verbal cues in an effort to prompt the disclosure. Purposefully withheld disclosure describes a victim who chooses to remain silent, despite having the opportunity to disclose abuse.

When the victim unintentionally discloses abuse, frequently in the presence of a third party who witnesses behaviour symptomatic of abuse, it is referred to as accidental disclosure. Triggered disclosure describes a victim who is exposed to an external sensory stimulant such as a sound, an object or an odour that triggers a memory and a response[6].

Kogan, a research scientist at the Centre for Family Research at the University of Georgia also differentiates between formal and informal disclosure. Formal disclosure is characterised by the victim making a formal, documented disclosure to the authorities. Informal disclosure occurs when the victim discloses abuse to a friend, a family member or another person. Kogan suggests that this type of disclosure is usually disjointed and vague, and is often lacking in details[7].

The first rule of medical practice is "Do no harm". By virtue of their direct contact with the patient during the treatment of physical injuries associated with abuse, EMS personnel and EC doctors may well be confronted with more than one type of disclosure. It is necessary to consider the extent to which a child who is brave enough to disclose abuse could be harmed by an inappropriate response (or worse, no response at all) from a medical professional to whom abuse is disclosed. The effective and compassionate handling of a disclosure of abuse must be regarded as an integral measure of the patient's treatment rather than a post-emergency treatment phenomenon.

2.2 Types of abuse

Abuse can be classified as physical abuse, emotional or psychological abuse, neglect or sexual abuse.

2.2.1 Physical abuse

EMS personnel are skilled at treating physical injuries. They are also able to recognise the particular stages of healing in which injuries present and determine whether these correlate with the patient history. Physical marks are the most common manifestations of physical child abuse[8]. These injuries may present dramatically and be clearly visible, or they may be more subtle and obscured by clothing or hair.

Signs of physical abuse include multiple fractures in varying stages of healing, bite marks (often found in areas concealed by clothing), bruises (particularly those manifested around the upper arm area), welts and cigarette burns.

Statistics show that in Princess Margaret Hospital, the main paediatric tertiary hospital in Western Australia, the number of children aged 0–17 years presenting with assault injuries between 1981 and 2005 increased from 2.8 per 10 000 children to 6.1 per 10 000 children. Admissions relating to maltreatment escalated from 0.7 per 10 000 children to 1.3 per 10 000 children. Of the children who were admitted to hospital, most of the physical trauma associated with assault included injuries to the skull, facial bones, wrists and hands. Injuries associated with maltreatment included superficial head wounds and abdominal injuries as well as an elevated incidence of intestinal infections and parasitic diseases.

Victim-offender assault relationships in the study revealed that 13% of offenders were family members or caregivers, while acquaintances accounted for 6.4% of offenders. Only 10.8% of the perpetrators of abuse were unknown to the victims. The remaining 49% were unspecified perpetrators and 11% had no coding for perpetrator (no fifth digit in the coding system used). The statistics do not account for the remaining 9,2% of perpetrators. The study also shows that 84% of injuries occurred at home[9].

A recent study conducted at the Red Cross Children's Hospital (RCCH) focused on statistics associated with the emergency-care management of physical abuse of children. The study had two purposes: to address the management of physical abuse of hospitalised children in the Western Cape with a view to establishing guidelines for other hospitals, and to quantify the extent of the problem in the Western Cape as observed at the Red Cross Children's Hospital.

The authors describe the lack of data pertaining to the physical abuse of children in South Africa as "disappointing". The study analysed hospital data compiled between 1991 and 2009 in order to establish types of assault presented by children who were treated in the EC. The study identified children presenting with non-accidental injury (NAI) at the RCCH Children's Trauma Unit over two years.

The RCCH documented 6 415 children who had been admitted to hospital as a consequence of assault. This translated into 4.2% of trauma admissions. Injuries included assaults with sharp and blunt objects, human bite marks and sexual assaults.

The study literature reports a marginal decrease in severe abuse over the past two decades. In-depth analysis of the RCCH records reveals that more boys (70.5%) were assaulted than girls (29.5%) during the period between 2008 and 2010. The practical implications of the study suggest that the training and diagnosis of child maltreatment should be researched in more detail[10].

A further study looked at the risk factors of children treated in an EC following both intentional and unintentional injuries as well as allegations of abuse. The life-to-death histories of 514 232 children entered into the child protection system as a result of maltreatment revealed that children who were frequently admitted to hospital owing to physical abuse faced the greatest likelihood of dying. One finding revealed that 1.7% of children who had previously made allegations of physical abuse subsequently sustained fatal injuries[11].

Medical personnel are expected to be skilled at recognising types of injuries as well as at treating them. Nonetheless, the National Center on Shaken Baby Syndrome in the US emphasises the difficulty of accurately diagnosing abuse. For example, a patient with abusive head trauma often presents with non-specific symptoms, including vomiting, lethargy and irritability. These symptoms may signify a host of other possible diseases and syndromes, resulting in frequent misdiagnosis of shaken baby syndrome[12].

2.2.2 Emotional or psychological abuse

Psychologists Twaite and Rodriguez-Srednicki contend that visible marks on a child's body signifying abuse are easier to see and thus easier to report than emotional and psychological abuse, which is invisible and so frequently remains unnoticed and thus unreported. The researchers conclude that despite the considerable attention devoted to the concept and the definition of emotional abuse, a universally accepted definition has yet to be formulated.

Definitions of emotional or psychological abuse focus on parental behaviour towards the child, with the impact of constant ridicule and humiliation being measured against the

child's responses. Twaite and Rodriguez-Srednicki also discuss instances or actions that do not constitute a verbal assault on the child. For example, when a child witnesses a physical altercation between his or her parents, he or she experiences feelings of fear, anxiety and uncertainty similar to those experienced by children living in a war zone[13].

It has been hypothesised that only the most serious cases of emotional or psychological abuse, where obvious abuse is present, reach the courts. This is damaging to the many children whose abuse is not recognised. These children are exposed to further victimisation in that their feelings about the abuse that they have experienced are invalidated by not being acknowledged[14].

Although emotional abuse is not fatal, it is silent and all-pervading. Doctors should be alert to symptoms that indicate possible abuse. For example, childhood obesity in the absence of any pre-existing medical condition is cause for concern, as is an underweight child who fails to thrive or achieve normal milestones. Emotional abuse may lead to self-destructive behaviour, may impact on the child's self-esteem and may delay attainment of developmental milestones. Social workers are overburdened by heavy caseloads and thus do not have enough time to observe parent-child interactions adequately and to implement preventative or intervention processes.

Abuse frequently presents as an act of omission, rather than an act of commission[15]. A classic example is a mother who does not intervene, but silently colludes with her partner's abuse of the child. Another example is a child who lives in a state of perpetual fear because he or she feels continuously threatened. The perceived threat may be direct or indirect, but it is strengthened by the parent's lack of interest in the child and failure to acknowledge him or her at any level.

The victim of abuse may find him- or herself isolated from other family members and friends. Emotional or psychological neglect may also be a secondary manifestation of a more serious issue. For example, financial constraints may prevent adequate parenting or a single mother may feel that she has no support mechanisms, which makes her prone to bouts of depression that further impact on the child.

A study focusing on families entered into the welfare system over a three-year period across 36 states in the USA established a significant link between maternal depression and poor parenting. The research examined whether depressed mothers disciplined their children in a way that was inappropriately harsh and whether depressed parents neglected their children. In addition, it assessed the likelihood of depressed parents maltreating their offspring. Results confirmed that depressed mothers both maltreated and neglected their children, in addition to punishing them harshly. It was concluded that depression impacted significantly on the parenting techniques of mothers[16].

2.2.3 Neglect

Detecting neglect is not always as easy as observing that a child is inadequately clothed. A young child left alone to his or her own devices without responsible supervision may not immediately appear to be neglected. Neglect may be an act of commission (for example, in the case of a malnourished child with severe kwashiorkor or marasmus) or it may be an act of omission (for example, when a child is denied prescribed medication).

A neglected child is one who lives in an environment that inhibits his or her mental and physical development. The child's potential physical, emotional and spiritual growth is delayed or stunted. Legislation in most countries prohibits child abuse and child labour. This is difficult to enforce in impoverished communities, where it is common for children to work in the family business, on the land or in a commercial endeavour of some description. In many developing countries, it is not uncommon for a child to be deprived of both a childhood and an education. The community perceives this to be a normal scenario; it is not regarded as abusive or neglectful. Even parents who may want their children to study in order to escape the cycle of poverty are placed in an impossible situation: they need their children to work in order for the family to subsist.

A Swedish study revealed that parents and careworkers often collude in concealing abuse. (For the sake of ease of reading, we will refer to caregivers instead of parents; the term caregivers as used in this document includes foster parents). Although cases of abuse were

detected by social workers, only a few cases were actually reported. This study was unique in that the careworkers lived with the families of disabled children. Disabled children, who are often unable to articulate their abuse, run a particularly high risk of abuse in such situations.

The incidence of non-disclosure of abuse was often determined by the relationship between the caregiver(s) and the careworkers. The child became further compromised and vulnerable when the caregiver(s) and the careworker enjoyed a close relationship as this greatly diminished the likelihood of the careworker reporting abuse or neglect by the caregiver. In one instance, a careworker who witnessed a parent pouring cold water over a child excused the behaviour as a result of the relationship that the careworker had established with the parent. The careworker denied that the behaviour was abusive and suggested that the parent was merely “uninformed”.

A significant contributing factor to the non-reporting of abuse was the concern of careworkers that if they reported abuse to social services and the family’s breadwinner was subsequently incarcerated, this action would have a negative impact on the survival of the family[17].

Studies conducted in the US confirm that abused children share this fear that their caregiver will be removed from the family and therefore often conceal their abuse[18]. The caregivers’ passive complicity in the abuse of a child may be motivated by the family’s economic circumstances. The complexities of the situation may not be immediately apparent to attending EMS personnel.

2.2.4 Sexual abuse

The statistics that are available on CSA do not give an accurate reflection of the number of sex crimes that occur since only cases that are reported to the authorities can be included in the statistics. A large number of sex crimes perpetrated against adults and children remain unreported. Statistics supplied by the South African Police Services have proven to be inadequate in reflecting the incidence and the type of crimes committed against children.

Recent crime statistics supplied in the 2012/13 report of the South African Police Services indicate that crimes associated with sexual assault have decreased from 69 117 cases reported in 2004/05, to 66 387 cases reported during 2012/13. The statistics, which are categorised by province, indicate that sexual assaults on children aged between 12 and 16 years in the Western Cape have decreased by 3.3% over the last four years[19].

Mandatory reporting of sexual abuse, which is legislated in the Children's Act, is not without complications. In addition, recent studies conducted in the Western Cape have indicated that social services are grossly understaffed. The most common difficulties cited were limited resources, increased caseloads and a backlog of cases awaiting legal prosecution[20]. These factors often mean that the healing process of child victims is delayed because psychological support is not immediately available to them.

CSA cannot be universally demarcated since definitions are neither absolute nor standardised. A concise definition describes CSA as "coerced or forced sexual behaviour, ranging from casual unwanted pinching to penetration, imposed on a child by a person five years older than the child"[21]. Although this definition seems clear, it ignores situations in which the abuse does not involve physical contact between the perpetrator and the victim, for example, exposure of a child to pornography. The definition of sexual abuse as "any act that exploits children, with or without consent, for the perpetrator's sexual gratification" is more inclusive since it incorporates both situations[22].

Children who are required to testify in court often experience secondary victimisation[23]. They are frequently "portrayed" during cross-examination as having lost their innocence as a consequence of their precocious knowledge and experience of sexual behaviour, and the language associated with it. Teenagers are often labelled as antisocial as a result of prior disagreements with social services. It is not unusual for them to be suspected of seeking retribution in custody cases. This common perception motivates many children not to disclose abuse. Most sexually abused children are familiar with the perpetrators of the abuse, making disclosure and reporting even more problematic[24].

Defining the social determinants of sexual abuse is not a simple task. They vary according to ethnicity, age, educational levels and psychosexual background of both perpetrator and victim. It is of paramount importance that medical personnel be familiar with family dynamics across the various cultures that exist in the Western Cape in order to understand specific cultural norms[25]. Male as well as female circumcision and facial scarification, for example, are considered the norm in certain cultures, while they are seen to be a form of child abuse in other cultures. In certain cultures, the idea of a nine-year-old child bride is inconceivable, whereas other cultures regard this practice as desirable, if not commonplace. Aboriginal Papua New Guinea allows for infanticide in order to control population numbers. According to custom, children are not regarded as fully human until they are a few years old[26].

Significant progress has been made in relation to the protection of children's rights in South Africa through the amendment of legislation relating to sexual offences, including the definition of rape. The amended definition states that "any person (A) who unlawfully and intentionally commits an act of sexual penetration with a complainant (B), without the consent of B, is guilty of the offence of rape"[27]. The previous statute defined rape as an act by a man against a woman. Any other form of penetration with an object was deemed to be indecent assault, and any form of sodomy was prosecuted as indecent assault and charged with a lesser sentence.

Specific charges pertaining to acts of a sexual nature against children include rape, incest, indecent assault, unnatural sexual offences, sodomy, bestiality, procurement for prostitution, sex tourism, subjecting a child to pornography and forcing a child to perform in a pornographic recording (which includes procuring and selling a child for the manufacture of pornographic material)[28]. There is no specific charge pertaining to CSA that includes non-contact crimes such as exhibitionism.

2.2.4.1 Sexual abuse and the Internet

Cyber-grooming (also known as online child grooming), a form of sexual abuse in which there is no physical contact between the victim and the perpetrator, is becoming increasingly common. Current research on cyber-grooming and the dissemination of online child pornography is inadequate.

Studies conducted in Germany show that unsupervised children who spend extended periods of time on their computers are considered to be especially vulnerable[29]. The risk factors associated with cyber-grooming are not dissimilar to the factors that enable physical acts of CSA. Extended periods of unsupervised Internet access and increased levels of risk-taking by children augment the probability of child cyber abuse[30]. In South Africa, factors such as speed of connection, limitations on data usage, the number of computers or smartphones per household, the costs of being connected to the internet and cultural differences will influence the level of exposure of children to cyber-grooming and online sexual exploitation.

Although boys spend more time on the Internet than girls, girls are more likely to be targeted for cyber-grooming. Statistics from the UK confirm that it is likely that 82% of girls will at some stage be asked to undress and transmit naked images of themselves on the Internet. They are perceived to be higher risk-takers than boys. However, boys are less likely to report incidences of cyber-grooming, fearing the same social stigmatisation that is engendered by offline grooming.

Social networking sites can be both beneficial and detrimental to users[31]. A paper presented at the 29th meeting of Interpol's specialist group on crimes against children in 2012 reported a new scourge: self-produced child pornography[32]. This form of pornography involves a paedophile using a webcam to manipulate a child into undressing in his or her own environment and posing for photographs. Prosecution of this crime is problematic since no force is used to obtain the child's co-operation. Since his or her participation has been voluntary and can thus be deemed to be consensual, it is not possible to allege enforced coercion, which is crucial when pressing charges. It is important to note that unless

the crime has progressed beyond cyber-grooming to physical assault and sexual abuse, EMS personnel are unlikely to encounter the victim. However, children who have already been exposed to other forms of abuse (such as parental neglect) could be considered especially vulnerable to this type of online abuse.

When EMS personnel are treating a child victim who discloses abuse that happened a long time ago, it is vital that the child's feelings of guilt, shame and self-blame be understood, along with the reasons for delayed disclosure. For example, the child may be distressed by the knowledge that his or her image will be disseminated worldwide via the Internet if they say anything. Perpetrators frequently use this knowledge to ensure that their victims remain complicit and afraid to disclose their abuse.

A study of 245 cases of child pornography and exploitation involving 197 girls and 48 boys revealed that the cyber-sexual abuse of children is constantly evolving, raising new issues that have not previously been encountered by childcare agencies. It is essential that knowledge systems and training methods be updated continuously in order to address the complexities of this form of sexual abuse adequately.

The study also acknowledged the permanent nature of images on the World Wide Web, which continue to exist long after the child becomes an adult. Images of this nature leave an indelible mark on the victim. It is for this reason that the parents of these victims are more likely to seek prosecution. Although pornography may form part of the online grooming process, parents are less likely to press charges against the perpetrator if the child has not been used in the creation of child pornography.

The therapists involved in the study concluded that, without exception, the victims of online sexual abuse experienced elevated feelings of guilt and shame. After treating these victims for a prolonged period, most therapists felt that they had been unsuccessful in allaying the anxiety of their patients relating to the endless dissemination of pornographic images of themselves[33].

2.3 The effects of sexual abuse on children

The negative effects of CSA have been well documented. It has been hypothesised that the consequences of childhood abuse are not limited to the period of the abuse. They continue to influence the victim well into adulthood. Evidence indicates that CSA survivors are less patient, more punitive and less affectionate towards their own children than people who have not experienced abuse of this nature. They frequently present with elevated levels of psychological aggression[34]. Recent studies posit that most children who experience sexual abuse also experience other forms of abuse, suggesting that CSA does not exist in isolation. Physical abuse, sexual abuse and neglect often occur in combination with psychological abuse. Survivors of CSA are prone to substance abuse, dysfunctional interpersonal relationships, control issues, compulsive behaviours and compromised sexual health.

Women who have experienced CSA are more likely to be the victims of other types of abuse. A negative sexual self-image dominates their sexual interactions. They tend to indulge in risky sexual activities, have more sexual partners and indulge in frequent instances of unprotected sex, often accompanied by the use of alcohol and drugs. This makes them more prone to sexually transmitted diseases. The participants revealed that they were sexually active at a much younger age than women who were not sexually abused[35].

A study conducted by the Offices of Men's Mental Health in Canada indicates elevated levels of stress in male adults who were abused as children. However, only some of the participants presented with a clearly defined psychopathology. The dominant variable indicates a correlation between men who experienced physical force during CSA and extreme mental distress as adults. Secondary factors included the trauma of non-disclosure over a prolonged period, reactions to disclosure and the subsequent difficulty of these men in conforming to the norms of their peers[36].

A study by Ullman et al. concludes that the effects and negative impact of CSA extend beyond the non-consensual sexual act into adulthood. The research explored the prevalence

of disclosure patterns and post-CSA depression by gender, confirming that CSA predisposes adult survivors to mental health issues. According to the study, women disclose abuse earlier than men, usually to a friend rather than a family member. The study indicates that gender is not a factor in reactions to disclosures of CSA[37].

2.4 Disclosure of abuse

Few studies have focused on the emotional aspects of the disclosure of CSA. As a result of the complications associated with the multi-faceted layers that precede disclosure or non-disclosure, not all children cry or become emotional during the disclosure process. This should not diminish what the child recounts because it is not unusual for children to disclose their abuse calmly.

Of the 124 children who participated in a research project about the initial forensic interviews done by child protection services, 75% showed no emotion when disclosing abuse. It was hypothesised that these children had realised from an early age that negative emotions or displays of anger would be ignored. EMS personnel involved in the disclosure process should not presume that information is fictitious if the child disclosing it is calm or emotionless[38].

For a child, the disclosure of abuse to an adult may be an extremely stressful process. Irrespective of whether the disclosure is formal or informal, many children choose to divulge information about their abuse to another child rather than an adult[39].

Current literature confirms that young children characteristically disclose abuse in a disjointed manner. For example, they may blurt it out during participation in an educational programme. In contrast, older children tend to be deliberate, weighing up the options of disclosure against the consequences for the perpetrator. However, the anger that some teenagers feel towards the abuser motivates them to disclose the abuse[40].

Dynamics play an integral role in how the disclosure occurs as well as the value of the information provided. The younger the child, the less likely it is that the disclosure process

will be coherent. Examples of ways in which young children may disclose abuse include responding to an indirect question or imitating an action through which they inadvertently reveal an inappropriate behavioural interaction with an abuser.

These findings are confirmed by a study conducted in KwaZulu-Natal involving 1 737 children who had disclosed abuse following prompting by a third party. In addition, this study established that the type of disclosure was determined by the age of the victim.

The study identified four categories associated with disclosure: accidental detection (43%), eye-witness detection (18%), purposeful disclosure (30%) and indirect disclosure (9%). The study confirmed that younger children are prone to explicit, accidental disclosure irrespective of gender. The study also established that a child who is being or has been abused by a family member is less likely to disclose the abuse than a child who is being or has been abused by a stranger[41].

2.4.1 Disclosure in the emergency-care setting

The nature of their work is such that EMS personnel spend very little time with their patients. They arrive at the location of the patient as rapidly as possible, stabilise him or her and conduct the handover to the emergency physician at the EC. However, EMS personnel who observe possible signs of abuse when they are called out to an emergency are well positioned to observe important details at the call-out, including the body language and reactions of the child and the caregivers, general living conditions and the mechanism of injury. These factors may corroborate or call into question narratives supplied by both the caregivers and the child.

It is imperative that the child be able to disclose abuse in a safe environment. Current research confirms that children need to feel safe and that they are not being judged before they are able to contemplate disclosure of abuse. The current curriculum pertaining to EMS treatment of child abuse emphasises the recognition of visible signs and symptoms and the treatment of associated injuries. However, recent literature focuses on the manner in which disclosure should occur, highlighting the need to create a safe environment for the child[42].

In situations where a child discloses abuse, EMS personnel need to be aware of the child's body language while demonstrating patience and understanding, all the while assuring the child of his or her safety. Most importantly, EMS personnel must be cognisant of the correct response protocols.

In her study Minnie, an ALS Paramedic, highlighted the need for additional training of Cape Town EMS personnel within the context of dealing with multiple deaths and bereavement. Her findings confirmed that although EMS personnel are trained to resuscitate patients and treat injuries skilfully and efficiently, they are not equipped to deal with the psychological and emotional impact that death has on either the family of a patient or themselves. The study indicates that despite encountering death and dying on a regular basis, 82% of the EMS participants believed that their bereavement training was inadequate. Respondents indicated that the bulk of their knowledge had been acquired through personal experience. This study confirmed that the training of EMS personnel focuses mainly on the treatment of physical injuries.

EMS personnel are not trained to attend to the psychological aspects of trauma in the field. Instead they are encouraged to leave it to professionals such as social workers and play therapists. It may be hypothesised that EMS personnel perceive their role as being twofold: to stabilise and treat a critically ill patient; to let psychological issues be taken care of by the "experts". When disclosure occurs various factors may exacerbate the interaction, for example, if a medical practitioner is ill-equipped or unwilling to deal with the issue, or if the healthcare practitioner has experienced child abuse him- or herself[43].

A lack of training often results in misdiagnosis. As a consequence many cases of abuse remain unreported. Inadequate training is cited as the main reason for the failure of medical personnel to report abuse.

Paediatrician Lisa Bunting conducted a study of medical personnel and draws similar conclusions to the study referred to above. In this study, only 21% of the patients who exhibited potential signs and symptoms of abuse were reported by the personnel who

participated in the study. The participants who did not report abuse claimed inadequate training and a fear of misdiagnosis as reasons for their failure to do so[44].

Another study considered five specific content areas relating to child abuse. These included medical evaluation, court testimonies, general impressions pertaining to the evaluation of child abuse, the interviewing of caregivers, and the identification and management of suspected abuse.

The interviews were transcribed in order to facilitate thematic analysis. The study illustrated the paucity of education pertaining to child abuse and neglect. It also indicated that misdiagnosis of abuse was rife as a result of inadequate training. This consequently placed the victim at risk of further abuse.

The fact that the participants had been trained in ten states in the US highlights the prevalence of inadequate training in the field of child abuse and neglect. With the exception of one participant, all of the members had received less than five hours of formal training on the subject.

A participant in the study expressed his frustration because he did not have access to a list of professionals who could expedite the victim's access to legal and social services. Another participant expressed concern that the caregivers seemed unaware of their neglectful parenting. (Neglect was the most common type of abuse encountered). Paediatricians in the group agreed that role-playing activities could impact positively on caregivers participating in training aimed at preventing child abuse and neglect. The study also revealed a need for easily accessible online information[45].

These findings are supported by recent research in the US in which teachers and healthcare professionals were tested on their skills and knowledge pertaining to the early detection of child abuse. Focus groups revealed that although participants were aware of the issue of child abuse and the protocols to be used in reporting abuse, they were not familiar with the most appropriate manner in which to handle the disclosure process. The study also

indicated that public healthcare workers and teachers focused on the prevention of child abuse through education rather than on the reporting of child abuse[46].

A study conducted in the ECs of public hospitals in Virginia focused on the ability of EMS personnel to treat sexual abuse victims. The research examined available structures and procedures and found that although the ECs could treat physical injuries associated with sexual abuse adequately, more than 50% of these centres lacked the essential resources required to treat victims. These resources include continuity of support, evidence collection, and collaboration with local law enforcement. A third of the ECs polled did not have a list of contact numbers for local rape centres or regular contact with these centres. Consequently, unnecessary delays while personnel obtained these contact details placed further stress on traumatised victims. Most significantly, the study found that 80% of participants in the study had either received no training or had not participated in refresher courses on the treatment of sexual abuse[47].

A study conducted on patients in mental health facilities in the US who presented with mild to chronic depression, post-traumatic stress disorder (PTSD), intimacy issues, promiscuity and drug addiction revealed a history of prolonged child abuse. Children who had been neglected, physically abused or sexually abused presented with more severe mental health issues than children who had experienced general trauma, such as watching a person die or being a victim of crime. This study theorised that children who have suffered prolonged abuse are more likely to experience secondary victimisation. For example, they may be blamed for the incarceration of the breadwinner and subsequent hardship and shame experienced by the family[48].

The study also concluded that child abuse affects the economic potential of the adult. Overall, patients who reported chronic abuse were found to have lower levels of education, earned less and possessed fewer assets than adults who had not experienced child abuse and had had supportive parents[49].

Numerous factors, including the victim's age and gender and the nature of the victim-perpetrator relationship, affect the disclosure process. Medical professionals must be

familiar with these complexities while always being aware that a lack of disclosure does not always indicate an absence of abuse.

Since no universally accepted methods or measuring criteria have been established, an objective, scientific study of disclosure is problematic, although studies unanimously concur that a safe environment is imperative to disclosure[50].

Professionals must be able to recognise non-verbal cues as signs of possible abuse. A child's reluctance to disclose abuse during a preliminary contact interview may require that the healthcare practitioner change his or her approach to disclosure. For example, the use of non-verbal cues such as open body language, maintaining eye contact and the appropriate tone of voice may help a child to overcome his or her unwillingness to disclose abuse[51].

Although these recommendations may seem obvious, it is imperative that professionals appreciate the amount of courage that a child requires when disclosing abuse and the degree of trust that must exist between the child and the practitioner before disclosure can take place. Trained EMS personnel who are familiar with the complexities of disclosure will understand the victim's need to hear reassuring phrases such as, "I want you to know that I believe you".

Worldwide training programmes such as "Safe To Say" inform children about abuse, and how and to whom they can report it. The "Safe To Say" initiative also targeted nurses working in ECs in the UK who were seeking to improve their competence and confidence when confronted with disclosures of abuse.

Fear of not being believed is a major factor that inhibits disclosure of CSA by children. Of 262 victims who had not previously disclosed abuse, 72% cited a fear of not being believed when the perpetrator was a close family member or a person of elevated social standing in the community. It is very difficult for a child to disclose abuse by a priest, for example, much less testify against a priest in court. Encouraging, reassuring phrases allow the child to suppress his or her fear of not being believed and to regain some sense of control. A guideline outlining response phrases is thus imperative [52, 53].

Social services personnel who take over from EMS members play a significant role in preventing further abuse. Social workers engage with the child, helping to resolve internalised emotions pertaining to the abuse while endeavouring to gain the support of family members. This does not, however, minimise the importance of the EMS paramedic who is often the child's first point of contact when it comes to disclosure.

A study of 38 adults who had disclosed child abuse revealed that 92% of them believed that they had been able to live a semi-normal life after disclosure. Post-disclosure, the participants reported that they had experienced fewer suicidal thoughts and had believed that an end to the abuse was possible. Being believed and reassured that they were not responsible for the abuse had created an enormous sense of relief in CSA victims[54].

2.4.2 Factors that influence disclosure

Factors that influence the disclosure of abuse include: the age and gender of the victim, the duration of the abuse, the type of abuse and the nature of the victim-perpetrator relationship[55].

2.4.2.1 Age

Young children usually disclose abuse by accident, while older children tend to disclose abuse intentionally. This is because a young child is often unaware that what he or she is experiencing is abusive. The child frequently perceives the abuse as "normal behaviour", although it makes him or her feel shameful, guilty and powerless[56]. These feelings are exacerbated in very young children who cannot understand what is happening to them. They are unable to process the feelings associated with the abuse. When the boundaries of trust of a small child are violated, he or she is left in a state of perpetual confusion.

It is important to remind a child who is disclosing abuse that he or she can tell the medical practitioner who is handling the disclosure anything, particularly when the child is struggling to find words or seems unable to articulate the abuse. In addition, the practitioner should not react to any displacement behaviour exhibited by the child but should affirm that the

child's behaviour is acceptable. The child must be reassured that he or she will not be judged. The EMS curriculum should include a component that instructs paramedics how to establish an emotional rapport with a victim of CSA. Various counselling and referral organisations involved in the post-disclosure process (for example, Childline) already have guidelines that concentrate on the child's cognitive ability to recall detail. However, EMS personnel do not have any point of reference. They are consequently further disabled from establishing an essential emotional rapport with the victim[57].

One strong motivation for disclosure is concern by an older child for siblings who are enduring similar abuse to them. Disclosure is usually motivated by a desire to protect younger siblings from being caught up in the same cycle of abuse that they were forced to endure.

The screening of educational films and school talks covering CSA at schools frequently triggers suppressed memories. A child may then approach a teacher, initiating the disclosure process by saying, "I think I was abused because …"

Anger towards the perpetrator is often not the primary reason for the disclosure of abuse[58]. The child often loves the perpetrator, but not what is being done to him or her. Young children sometimes feel responsible for the abuse, believing that "this bad thing" is happening because they are bad. The low self-esteem of some children leads them to rationalise the abuse by concluding that they deserve it. Young victims frequently believe that they are "dirty" and avoid playing with other children because they believe that other children also perceive them as dirty[59]. As the child grows older the feelings of being "dirty" may lead to a host of destructive behaviours including eating disorders, antisocial behaviour and aggression, truancy, running away from home, drug abuse and poor hygiene. The abused child believes that he or she is not worthy of love and attention[60]. Older children may resort to displays of anger and destructive behaviour that challenge their parents. It is essential that parents receive adequate counselling and support to help them deal with a child's rage. ECs should supply parents with contact numbers for parental support services.

Once abuse has been exposed some parents remove their child from school. This is a common mistake since it conveys to the child the negative message that he or she has done something wrong and deserves to be punished. In addition, this further isolates the child from "normal" life and his or her peers. Counselling will assist the parents and the child in processing the anger associated with the abuse.

2.4.2.2 Gender

Social conditioning teaches girls to share and discuss their feelings. They are consequently more likely than boys to disclose abuse. Schoolboys are taught from a young age to channel aggression into physical activities. Boys, particularly those who have endured sexual abuse, are often concerned that their friends will perceive them to be victims or homosexuals if they find out what has happened.

Both genders fear that they will not be believed if they disclose the abuse. In instances of undisclosed sexual abuse, boys tend to display aggression, while girls tend to present with mood disorders. Our entrenched patriarchal system discourages disclosure. Most boys believe they should "man up" and simply handle the abuse. In a restricted environment where many boys are abused by a single perpetrator, disclosure is particularly problematic[61].

Children who conceal abuse may experience secondary victimisation. A study revealed that a less common reason for non-disclosure is that male adult survivors fear that they will be regarded as potential abusers[62].

2.4.2.3 Type of abuse and duration

Empirical research confirms that prolonged abuse manifests in a range of mental health disorders. Men who have experienced prolonged abuse as children present with depression, PTSD or obsessive compulsive disorder (OCD). Contributing factors include the period of abuse, the age of the victim, the nature of the offender-victim relationship, whether or not there were multiple perpetrators and whether or not physical force was employed. The

most common factor among depressed men involves penetration and the use of force when the act of sexual abuse is committed. The use of force prior to or after the abuse did not emerge as a significant factor.

The men presenting with the highest scores for mental stress had been abused for more than a year in situations where the use of physical force was constant. Most participants disclosed the CSA more than two decades after it was committed. There may be a direct link between this delay and the level of psychological stress experienced. A third of the participants stated that a positive, sympathetic response to their disclosure had been beneficial. The extent of the trauma affected the timeframe of disclosure, which in turn affected the degree of mental stress experienced[63].

2.4.2.4 The victim-perpetrator relationship

Children who are abused by a stranger are more likely to disclose the abuse. Younger children tend to be more concerned than older children about what will happen to an abuser who is known to them and how he or she will be punished. Older children tend to indulge in antisocial behaviour and occasionally display obsessive compulsiveness in an attempt to regain a semblance of control over their world.

Abused children, particularly those who are sexually abused, may believe that they are not worthy of attention or love[64]. Intra-familial abuse elicits greater social outrage than abuse that is perpetrated by a stranger. It has been argued that intra-familial abuse has far more serious long-term consequences than extra-familial abuse. When the boundaries between a parent and a child have been transgressed the child feels betrayed and confused and unable to rely on the parent's protection. The child becomes suspicious and mistrusting. This situation may continue into adult life, affecting the victim's relationships. Abuse, particularly sexual abuse by a parent, impacts negatively on the victim's future ability to enjoy the intimacy of a normal, healthy sexual relationship[65].

2.4.2.5 Social conditioning and culture

When families emigrate, their traditional cultural practices may clash with the beliefs and practices of their new country. Child-rearing practices vary across races, religions and cultures, which may skew reported statistics of child maltreatment[66]. In some cultures harsh punitive measures are regarded as an acceptable form of child discipline, while in other cultures these measures are considered abusive. Educators in a South African study expressed how disempowered they felt when legislation was changed and they were no longer allowed to use corporal punishment as a disciplinary measure for high school students[67].

Many cultural customs and differences have no negative impact on children. For example, it is customary to shave a baby's head in India, while Orthodox Judaism forbids the cutting of a boy's hair until he is three years old. However, Chinese children (and adults) are traditionally disciplined via a "name-and-shame" system[68]. If a young child commits a transgression he brings shame on him- or herself and, by association, shames his or her entire family. The victim subsequently feels guilty and ashamed of him- or herself and of shaming the family, thereby amplifying the burden of guilt. This type of punitive behaviour has been linked to delinquency, low self-esteem and extreme aggression at an older age[69]. The marked differences in parenting styles of Americans and Chinese immigrants to America illustrate how one group's cultural norms can be considered to be abusive by another culture.

A child who lives under one roof with the members of his or her extended family has less opportunity to disclose abuse. The child's sense of isolation and powerlessness is magnified. However, a child living in a nuclear family has more opportunities for disclosure of abuse.

A child who belongs to a family that is aligned to a strict religious sect whose members are accountable only to the leader will have few opportunities to disclose abuse. Some religious groups dictate a strict, punitive relationship between parents and their children. Abuse flourishes in circumstances such as this. Children are raised in an environment that hinders their ability to comprehend their feelings of guilt, shame and confusion. Culture and religion

are dominant influences that affect a child's readiness to disclose abuse. In some cases they remove the child's right to question anything, including abuse.

2.4.3 Understanding non-disclosure

It is as important to understand non-disclosure as it is to understand disclosure, particularly when the patient's recall of events leading to the mechanism of injury does not correlate with the injuries presented.

If a child perceives the environment to be unsafe, it is highly unlikely that disclosure will occur. Conflicting family loyalties and the pressure of being urged to disclose abuse may make the decision to disclose abuse more difficult for the child. Many studies on disclosure have noted the occurrence of a specific type of behaviour exhibited by chronically abused children that is known as "child sexual abuse accommodation syndrome". Summit, a clinical associate professor of psychiatry at Harbor-UCLA Medical Center contends that when the abuse is disclosed, the child faces secondary victimisation similar to that experienced by a rape victim who is cross-examined by the defence in a court of law[70].

A child who presents with this syndrome has successfully accommodated his or her behaviour towards the abuse and acts "normal", making it difficult to ascertain whether or not the alleged abuse actually occurred. Behaviour linked to child sexual abuse accommodation syndrome differs from the stereotypical conventions and reactions expected of an abused child. A child may choose not to persist in attempting to disclose abuse if his or her allegations are frequently met with disbelief and he or she is accused of lying, or is threatened or bribed. A child who feels abandoned or betrayed by the people who should normally protect him or her may feel motivated to conceal the abuse.

A child who has experienced abuse may internalise feelings of self-hatred, concluding that he or she is to blame. Summit contends that it is imperative to understand the evolution of the child's reactions to the victimisation and identifies the following five key components of the process: (i) secrecy (ii) helplessness (iii) entrapment and accommodation (iv) delayed, unconvincing disclosure (v) retraction.

Consequently, full disclosure occurs only through repeated interviews and prodding. Attempts to extract information directly after the primary disclosure should be eschewed in favour of open-ended, neutral questioning[71].

Research involving 24 young children admitted to social services in the US confirmed the abused child's need to feel safe before he or she will disclose abuse. Many children delayed disclosure of abuse because they did not feel safe[72]. Although it may not always be possible for paramedics on the road to create a safe situation for disclosure, this should be the primary concern of EMS personnel who encounter evidence of abuse. In a hospital setting, a private examination room should be made available for abused children. While financial and space constraints may impact on the availability of a facility such as this, hospital management should endeavour to provide a suitable private space.

The readiness of caregivers to report CSA is influenced by the perception of the degree of violence used. Seven possible treatment strategies were made available to 153 caregivers who participated in a study on reporting of abuse. The objective of the study was to assess how caregivers would rate the urgency to report an abusive situation. The treatment practices in question were based on common practices for treating and responding to children who disclosed abuse.

The situations presented in this study ranged from minimal contact with the child to extremely invasive contact. The study revealed that the age, gender and race of the child played no significant role in the reporting of the disclosure.

The research showed that in the event of invasive sexual acts, the caregivers unanimously chose to take the child to an EC[73]. However, children who had minimal or no contact with the abuser, and those who disclosed non-penetrative abuse, were not perceived to be urgent cases. In these scenarios, the caregivers elected not to report the matter to the police. This situation is particularly dangerous because instead of the child entering into the system, he or she remains vulnerable and in a position of exposure to further abuse.

2.5 Training of emergency medical care providers in the Western Cape

Training for emergency-care providers is offered by the Western Cape Government College of Emergency Care, the Cape Peninsula University of Technology (CPUT) and the University of Cape Town. CPUT offers degree courses comprising of a Bachelor of Emergency Care (BTech), a Bachelor of Emergency Medical Care (BEMC) and a Master of Emergency Medical Care (MEMC). The Master of Medicine (MMed) in Emergency Medicine is a four-year postgraduate degree offered by the University of Cape Town to doctors who have completed the Bachelor of Medicine and Surgery (MBChB) degree. This degree trains students to be specialists in emergency medicine. ECs in Cape Town are increasingly staffed with trained emergency physicians.

EMS personnel are skilled at using life-saving equipment and procedures to treat any medical or trauma-related emergency. Their scope of practice is extensive, as is their knowledge of the pre-hospital stabilisation of critical patients. The training curriculum emphasises the identification and treatment of medical emergencies. However, as stated earlier, child abuse receives little attention in the current curriculum. A short section identifies various forms of abuse. The subjects of disclosure, non-disclosure, catalysts of disclosure and the psychological state of victims are not covered. Disclosure of child abuse has been and is still perceived to be a phenomenon best left to social workers and psychologists, who are summoned after the child has been treated and, in some cases, post-disclosure.

The attached appendices A, B and C support the statement that the curricula of the BLS, ILS, ALS and MMed qualifications are limited to the identification of the physical signs and symptoms of child abuse as well as the treatment of child abuse. There are no recommendations or guidelines on disclosure, non-disclosure or the disclosure process (the MMed curriculum does include a short section covering the spectrum of child abuse and neglect, but it does not discuss disclosure or recommended responses to disclosure). It is imperative that medical personnel comprehend the spectrum of child abuse and

acknowledge that disclosure is not a separate entity that is to be handled by another professional.

2.5.1 Professional accountability

The legal responsibility of EMS personnel to report abuse or suspected abuse is dictated by The Children's Act No. 38 of 2005, amended by The Children's Act No. 41 of 2007[74]. EMS personnel must appreciate their ethical position, which is widely regarded as one of compassion and trust. EMS personnel should be cognisant of their legal obligation to report even suspected child abuse. Furthermore, EMS personnel should be familiar with the legal protection afforded to them: they cannot be sued by parents or caregivers since the reporting of abuse is in the best interests of the child.

The ideal environment for disclosure is a tranquil child-friendly room, free from interruptions and telephone calls. However, an environment of this nature is not always available. Nonetheless, if EMS personnel are educated about the factors that contribute to or inhibit disclosure, they are likely to endeavour to uphold as many of these features as possible in the circumstances presented to them.

It is imperative to acknowledge the diverse scope of child abuse, which transcends culture, race, religion and social status. Child abuse is not limited to poor families in which alcohol abuse is apparent. A lack of training about how to handle disclosure of child abuse has a negative impact on paramedics who report experiencing feelings of inadequacy, failure and in some cases, PTSD. These responses have been confirmed by paramedics employed by Cape Town's Emergency Medical Care Providers.

CHAPTER 3: METHODS

3.1 Study design

A descriptive study was undertaken in the form of a questionnaire-based survey including two parts: perceived knowledge and actual knowledge related to child abuse (Appendix D).

A professor of statistics was consulted and various study approaches were discussed. These included qualitative methodology with structured or semi structured interviews and focus group discussions. It was determined that a quantitative survey would be the best approach for addressing the research question and extracting the data needed. The survey instrument was created de novo and has not yet been validated because a study of this kind has never been implemented before.

Finally, in order to equally assess perceived and actual knowledge across all levels of EMS personnel, it was decided that a final number of 30 participants from each level – EM Registrars, ALS, ILS and BLS – would be included in the study.

3.2 Study population and sample

The Cape Town Emergency Medical Services currently employs 1 780 medical professionals, of which 1 582 are actively operational in the public sector.

The participants of the study comprised emergency medical services personnel and emergency medicine registrars within the Cape Town metropolitan area. Personnel excluded from the study were lecturers, administrators, control room personnel and volunteers. Only operational EMS personnel were included as they were most likely to be the first point of contact for a child presenting as an emergency having experienced abuse.

Due to time and accessibility constraints, the researcher visited the largest and busiest ambulance stations in the Cape Town metropolitan area until the required number of volunteers from each level had been obtained. The EM Registrar questionnaires were

collected at a CME for doctors. Of a potential 150 EMS personnel who had the opportunity to take part, a total of 126 respondents completed the questionnaires equating to a response rate of 84% of those invited to participate. The respondents included in the study account for 7.8% of all operational EMS personnel within the Western Cape Metropolitan area.

The final sample group consisted of 30 Basic Life Support, 30 Intermediate Life Support, 30 Advanced Life Support paramedics and 30 EM registrars. Six respondents were not included in the study because their questionnaires had not been completed or their consent forms had not been signed.

3.3 Data collection

The questionnaire comprised a total of 34 questions. Questions 1–9 included an ordinal response scale of Strongly Agree, Agree, Disagree, Strongly Disagree. Strongly Agree and Agree responses were grouped into a positive response, while Disagree and Strongly Disagree were grouped into a negative response, thus effectively turning Questions 1–9 into a binary response scale. Questions 10–33 had a binary (Yes/No) response. The questionnaire ended with one narrative response (Question 34) describing an experience. Data were collected over six months from 1 February 2012 to 31 July 2012. Participants were asked to either complete the questionnaires via an online Google document or via hard copy. All questionnaires had to be completed and returned with a signed consent form. Personal details on the questionnaire were limited to the age of the participant, years of service and the respondent's qualifications.

3.4 Ethics and data management

This study was approved by the Human Research Ethics Committee of the University of Cape Town (REC Ref 114/2012) (Appendix E).

Participant anonymity and confidentiality were maintained throughout. All data were entered into a password-protected database and codes were used to identify individual

participants. Hard and soft copies of questionnaires and all signed consent forms were securely stored for reference. Incomplete questionnaires were discarded and not included. Since only one answer to each question was permitted, questionnaires with multiple answers were discarded. Additionally, questionnaires unaccompanied by a signed consent form were excluded from the research.

Participants were informed that they could refuse to take part, and that they may withdraw from the study at any time. Furthermore they were provided with information to access support within their own service should they feel the need to do so at any time during or after the study.

3.5. Data analysis

Data were entered into a password-protected excel database and SPSS was used to provide descriptive statistics and comparative statistics for different cadres of emergency care providers using Fisher's Least Significant Difference Test (LSD). P values were reported for all LSD tests that found significant differences. The questionnaire comprised 9 questions with an ordinal response scale that was subsequently reduced to a binary (positive/negative) response scale during analysis, 24 questions with a binary (Yes/No) response and one open-ended question requiring a narrative response describing an experience. Answers to the open-ended question were not a prerequisite for inclusion in the study. The responses were collated and summarized according to emerging themes.

CHAPTER 4: RESULTS

126 questionnaires were completed and 30 from each of the 4 cadres of emergency care professionals were selected in the order in which they had been submitted. Questionnaires that were not completed were discarded and replaced by one of the remaining 6 questionnaires matching the same qualification level, again selected in the order in which they had been submitted. Age of participants ranged from 22–51 years and was not directly proportional with work experience. The participant's experience ranged from eight months to 28 years.

Qualification	Number of respondents	Median age	Range	Median range of Years of experience
Doctors	30	35.5	29–42	3–15
ALS	30	40.0	29–51	5–26
ILS	30	32.5	22–42	3–21
BLS/BAC	30	34.5	24–45	8/12–20

Table 1: Demographics of respondents

Two aspects were investigated in the survey. The first section (Questions 1–9) explored the perceived knowledge and training of EMS personnel, specifically within the context of treating child abuse. The second section (Questions 10–33) established the actual knowledge and training of EMS personnel when required to attend to incidences of child abuse. The answers in Section 2 reflect the actual knowledge of the respondents with regard to the legal, medical and psycho-emotional aspects of treatment in cases of child abuse.

A final question (Question 34) required the respondents to narrate cases of abuse that they had attended to, as well as their feelings after the event.

4.1 Perceived knowledge and training

Section one of the questionnaire – *Perceived Knowledge and Training* – was used to determine how adequately respondents felt their training had prepared them to deal with the various aspects of treatment when abuse was evident, suspected or disclosed. Data were extracted to determine respondents' confidence levels when treating victims of child abuse and children who disclose abuse.

Participants responded on an ordinal scale indicating the degree to which they felt adequately prepared by their training to deal with legal, administrative and emergency care aspects of child abuse. 'Strongly agree' and 'agree' were merged as a positive response, indicating that respondents felt adequately prepared by their training, and 'strongly disagree' and 'disagree' were merged as a negative response, indicating that respondents did not feel adequately equipped or prepared by their training. The different aspects of treatment covered by this section included: (i) legal requirements, such as reporting and completing the relevant forms (ii) behaviour, such as what to say and how to act towards the child (iii) practical considerations, such as making the child comfortable; treating physical injuries; managing the scene and dealing with the caregivers; and completing patient reports forms (iv) psychological/emotional issues, such as being aware of and dealing with the psychological and emotional space of the child during treatment.

The majority of the EM registrar group agreed (90%) that they felt adequately trained and prepared in what is legally required of them when a child presents with obvious signs of abuse. Just over half of the EM registrar group (53.3%) felt adequately trained in how to complete the necessary legal documents, such as the Patient Report Form and the J88, and 93.3% of the EM registrar group agreed that they were able to complete all sections of the J88 (Appendix F) as required by SAPS.

This cadre of emergency care providers felt less adequately trained and prepared in understanding the emotional space of the child that presents with obvious signs of abuse, with only 50% feeling adequately trained; what to say and how to respond to a child that discloses physical or sexual assault during treatment generating a 46.7% positive response towards their training; and dealing with the psychological and emotional aspects of child abuse during treatment generating only a 26.7% positive response towards their training.

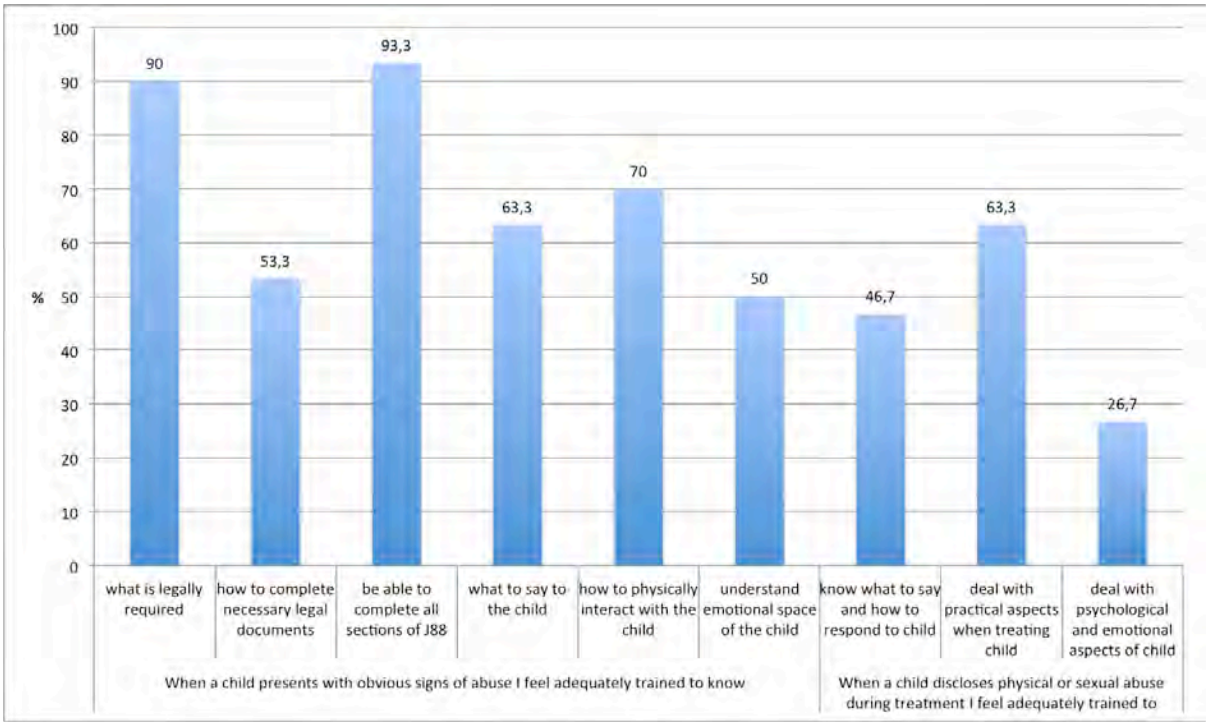

Figure 1: Graphical representation of proportion of those who responded affirmatively to each question among EM registrar group for section one.

Just over half of the ALS and ILS groups felt adequately trained to know what is legally required of them when presented with obvious signs of abuse, with only 53.3% of ALS showing confidence in their training and 56.7% of ILS showing the same. ALS providers felt inadequately trained on all aspects covered in section one. They felt the least adequately trained on how to complete the necessary legal documents (13.3% positive response) and

how to deal with psychological and emotional aspects when a child discloses physical or sexual abuse during treatment (10% positive response).

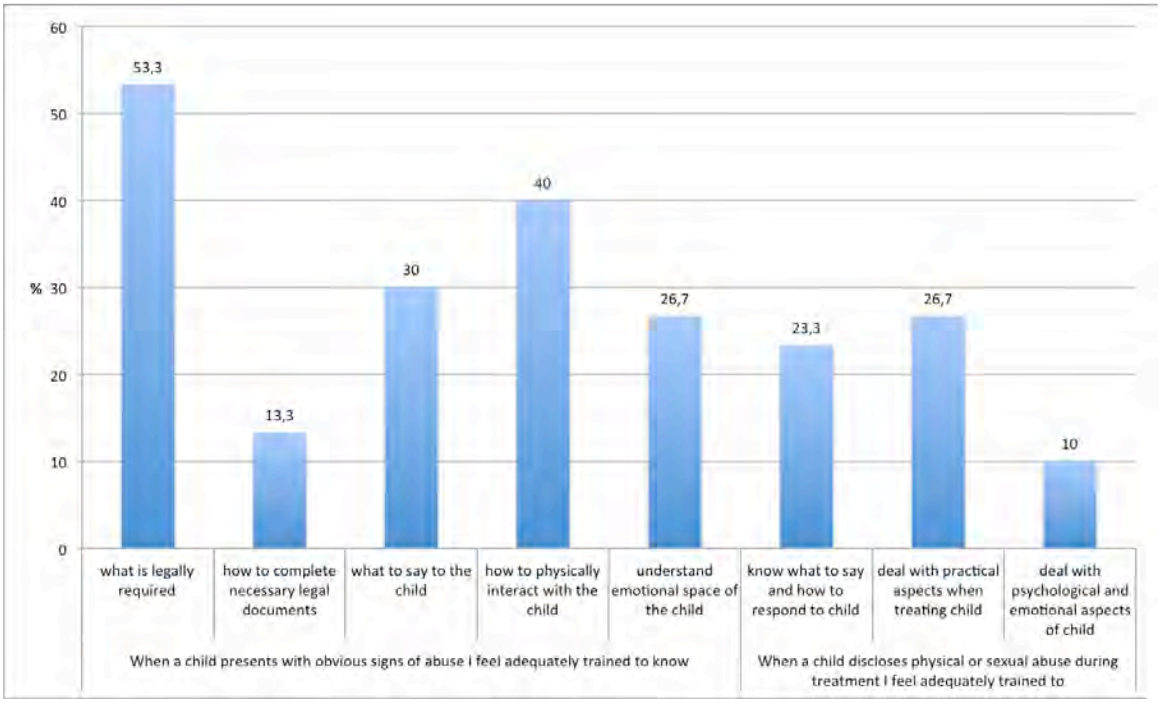

Figure 2: Graphical representation of proportion of those who responded affirmatively to each question among ALS group for section one.

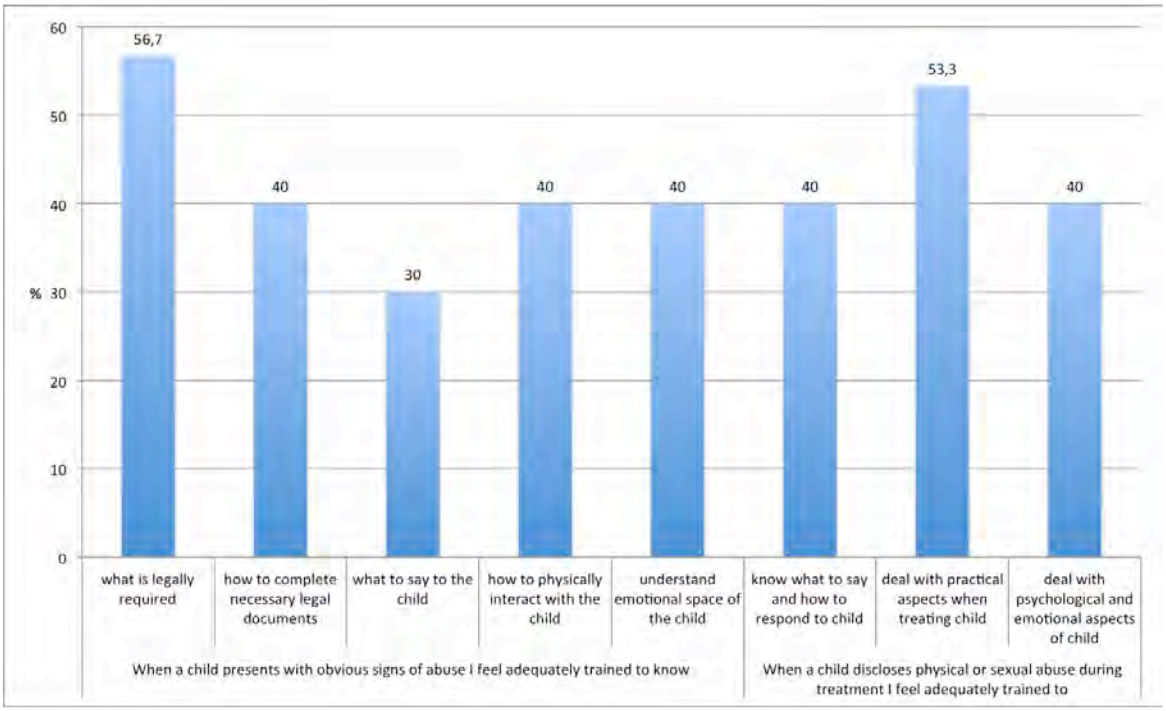

Figure 3: Graphical representation of proportion of those who responded affirmatively to each question among ILS group for section one.

Within the pre-hospital care providers, the BLS group felt more adequately trained and prepared (66.7%) to know what is legally required of them than knowing about other aspects of management and care such as what to say (43.3%), how to physically interact with the child (43.3%), how to deal with practical aspects when treating (40%) or how to deal with the psychological and emotional aspects of abuse (36.7%) covered in section one.

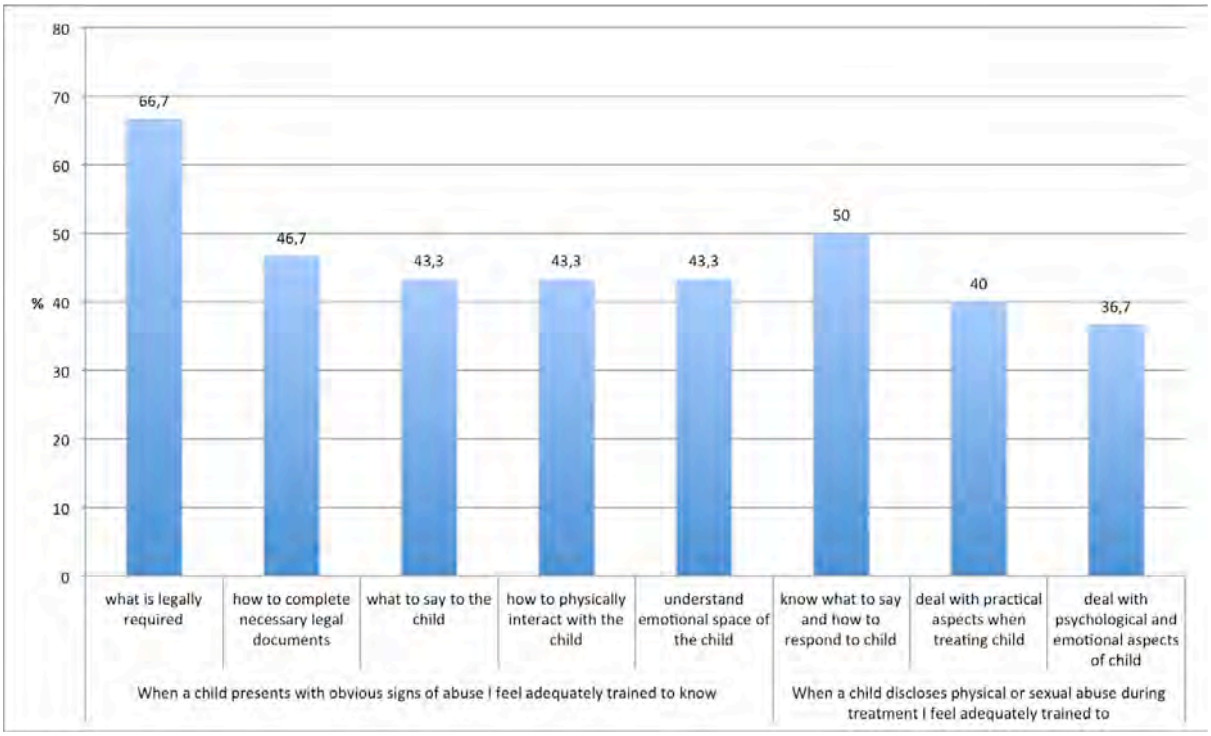

Figure 4: Graphical representation of proportion of those who responded affirmatively to each question among BLS group for section one.

Despite the fact that ALS, ILS and BLS are taught to report abuse, and that more than half of these respondents believed that they were sufficiently equipped, when questioned on their actual knowledge, most of the respondents stated that they were under no obligation to report abuse if it was only suspected rather than confirmed. All of the EM registrars agreed that they had to report suspected abuse, but only 16.7% of the ALS group, 63.3% of the ILS group, and 50% of the BLS group believed the same.

Furthermore, the correct procedure of who to report suspected or confirmed abuse to was overwhelmingly incorrect. A total of 91.7% respondents believed that they needed to report the case to their station commander or, in the case of EM registrars, to the hospital superintendent. Child abuse should in fact be reported to the SAPS or a social worker. This data confirms that although EMS personnel are trained to report child abuse, it is not clear

in their training who the abuse should be reported to. The obligation of EMS personnel to report suspected abuse is also not impressed during training.

There was a significant difference between the high percentage agreement of perceived knowledge among EM registrar group (90%) and low percentage of agreement of perceived knowledge among the ALS group (53.3%) (p=0.0024).

Questions from section on perceived knowledge	**Fishers LSD Test**	**P value**
Know what is legally required when child presents with obvious signs of abuse	EM reg (3.1) ALS (2.5)	0.0024
Know how to complete legal documents when child presents with obvious signs of abuse	EM reg (2.6) ALS (1.8) EM reg (2.6) ILS (2.5) ALS (1.8) BLS (2.5)	0.0001 0.0009 0.0006
Know what to say to the child when child presents with obvious signs of abuse	EM reg (2.7) ALS (2.2) ALS (2.2) BLS (2.6)	0.013 0.032
Know how to physically interact with the child when child presents with obvious signs of abuse	EM reg (2.8) ALS (2.2)	0.005
Know what to say and how to respond to a child that discloses physical or sexual abuse during treatment	EM reg (2.5) ALS (2.1) ALS (2.1) BLS (2.5)	0.035 0.023
Prepared to deal with practical aspects when treating a child that discloses physical or sexual abuse	EM reg (2.7) ALS (2.0) ALS (2.0) ILS (2.6)	0.001 0.005
Deal with psychological and emotional aspects when a child discloses physical or sexual abuse	ALS (1.9) ILS (2.4) ALS (1.9) BLS (2.3)	0.005 0.024

Table 2: Comparative statistics using Fishers LSD with p values.

Verbal response during treatment includes knowing what to say and what not to say to the child if abuse is suspected or confirmed during an examination. Only 41.7% of all respondents felt that they were adequately trained in this regard. Within each sub-group, 63.3% of EM registrars felt adequately prepared while only 30% of ALS and ILS staff

respectively felt adequately equipped. Despite their much lower level of training and high levels of inexperience 43.3% of BLS felt that they knew what to say in such a situation.

Of all the participants taking part in the study less than half (45.8%) felt that their training had adequately prepared them to deal with the practical aspects of treating a child who had been abused. EM registrars formed the highest positive number, with 63.3% feeling confident. Only 26.7% of the ALS group felt adequately prepared, while 53.3% of the ILS group checked in positively and 40% of BLS felt adequately trained and prepared.

Dealing with the emotional and psychological space of the child during treatment scored the lowest percentages in section one with only 28.3% of all respondents feeling adequately trained to do so. Despite their lower level of training 40% of the ILS and 36.7% of the BLS personnel felt adequately prepared. However, only 26.7% of the EM registrars felt as prepared and an even lower 10% of ALS personnel felt their training had adequately prepared them to deal with the psycho-emotional space of the child.

While most of the questions in section one focused on dealing with suspected or confirmed abuse, Question 6 specifically asked whether EMS personnel felt their training had equipped them to deal with a disclosure by the child. Only 40% of the entire group felt adequately trained to deal with disclosure. BLS personnel showed the highest agreement with 50% responding positively, while EM registrars followed close behind with a 46.7% positive response. Only 40% of ILS felt adequately prepared with ALS showing the least positive response to their training – only 23.3% responded positively.

In comparison with section one: Perceived Knowledge and Training, EM registrars expressed greater confidence around the practical aspects of treatment whereas ILS and BLS felt greater confidence when confronting the less tangible (more emotional) areas of treatment. Of all the sub-groups, ALS had the least agreement when dealing with all aspects of child abuse – both the practical and the less tangible.

When performing a comparison of the overall positive versus negative responses between the different sub-groups for section one, it can be seen that EM registrars felt the most

comfortable and well equipped. The ILS and BLS levels were more or less equally split when it came to their feelings of adequacy and confidence in their training. However, the ALS group felt the least trained and prepared despite their level of experience and long service in the EMS arena.

4.2 Actual knowledge

Section two tested respondents' actual knowledge of child/sexual abuse by presenting questions that had only one possible correct answer. Respondents were required to provide a yes or no answer to each question.

In contrast to the relatively poor levels of agreement around preparedness and training when dealing with the non-physical aspects of child abuse, as was apparent in section one, almost all respondents (91.7%) agreed that when a child starts disclosing abuse during treatment, the reaction of the attending EMS personnel to the disclosure can have a long-term effect on the child's feelings of self-esteem and wellbeing. All of the EM registrars (100%) and almost all of the ALS (93.3%) felt this to be true. The ILS and BLS personnel were also in agreement with 86.7% of respondents in each group responding positively to the question. The reaction of the attending EMS personnel to the disclosure definitely can have a long-term effect on the child's feelings of self-esteem and wellbeing, which makes agreement with the statement the correct answer.

When asked if, when abuse was suspected, it was advisable to question the child further about the abuse and the identity of the perpetrator, just under half of all respondents (45%) replied in the affirmative. This is actually not recommended. Almost all respondents (97.5%) agreed that it was important to understand why children do not disclose and a further 89.2% agreed that all children disclosing abuse should be taken seriously, regardless of their age.

Question 13 asked: *"If child abuse is just suspected, rather than obvious or confirmed, you are under no obligation to report it."* All of the EM registrars and 83.3% of the ALS group agreed that suspected abuse had to be reported, but only 63% of the ILS and 50% of the BLS

believed that reporting of suspected abuse was necessary. All abuse, even suspected abuse, must be reported.

Question 26 posed the following to participants: "*You can be held liable, or sued by the defendant, if you report a case of suspected abuse, and the court rules that it was not*." Within the EM registrar group 83.3% responded correctly by saying that personnel could not be held liable. However, only 30% of ALS, 40% of ILS and 43.3% of BLS responded correctly.

The respondents' legal knowledge around abuse was inaccurate. For instance, when asked in Question 11: *"According to the law, inserting an object into the vagina of an unconsenting female is known as sexual assault*", 96.7% of all respondents agreed that this was the case. Under the new definition, this is no longer considered sexual assault, but rape.

Respondents were also asked whether allowing a rape victim to urinate before the vaginal vault is swabbed for DNA evidence would obliterate the evidence (Question 18). Only 66.7% of EM registrars and 60% of ALS responded that it would not. Half of the ILS (50%) and more than half of the BLS (60%) believed that the evidence would be obliterated. The correct answer is that urination does not obliterate the evidence. Of the EM registrars 40% also agreed that the examination of a sexually abused child should always be done under anaesthetic. Of the other groups 66.7% of ALS, 33.3% of ILS and 50% of BLS thought the same. This is incorrect; only when the child is too traumatised to lie still and be examined and photographed, should the examination be done under anaesthetic.

When asked whether they had seen a list of contact numbers or resources for reporting cases of child abuse in their workplace, 39.2% of respondents confirmed that such a list was displayed in their workplace.

Finally, Question 15 of the questionnaire forming part of this study, aimed only at EM registrars, reads: "*As a medical professional examining the patient and filling out the J88 form, you are not required to fill in the mental state of the victim at the time of examination."* Two participants out of the 30 incorrectly responded that they were not

required to comment on the mental condition of the patient. In fact, the mental condition of the patient is important and must be included on the J88.

The last section of the questionnaire included a qualitative question that required respondents to describe how they felt after treating a victim of child abuse (Question 34). From the entire sample group of 120 participants, only 16 participants completed this section. Eight were EM registrars, six were ALS paramedics and two were ILS paramedics. No BLS completed this question. The low number of responses to this question could be the result of varying experience with child abuse among the different groups surveyed, with some possibly never having attended a call involving child abuse before or not being aware of such if they had. Time constraints when completing the questionnaire could also have been a factor.

Participant 81, a 30-year-old ALS paramedic with five years experience	"*It was difficult to deal with the emotional side of the patient because she felt uncomfortable around us paramedics. It was overwhelming, and I was not sure how to handle the emotional side. I felt so helpless.*"
Participant 38, a 43-year-old ILS paramedic with six years experience	"*Confused, not knowing what to do.*"
Participant 64, a 30-year-old ALS paramedic with seven years experience	"*Treated a 12-year-old with suspected sexual assault, also head trauma. Went to the rape crisis centre at Karl Bremmer and was told they cannot help the child. We needed to proceed to Tygerberg Hospital. The running around from one hospital to another was frustrating, but having to explain the situation to the child who believed nobody wanted to help her made me want to cry in helpless fury*."
Participant 34, a 34-year-old ILS paramedic with 10 years experience	"*Due to the difficult lack of training in our workplace, under-treatment was given to the patient. I told her she did not need to feel ashamed, because she was not to blame for what happened. Felt emotional, disappointed and frustrated...*"
Participant 84, a 38-	"*Reassured child; attempted to gain child's confidence; transported with SAPS escort. I felt*

year-old ALS paramedic with 20 years' experience	*undertrained and ill-equipped to handle the child and the scene. I was not sure of my legal role and what I was allowed to say and do*."
Participant 95, an EM registrar with 10 years' experience	*"It made me feel uneasy that I may legally destroy evidence or do something wrong that would jeopardise the case; I would like more training."*

Table 3: How respondents felt when dealing with cases of child abuse

Themes that kept emerging repeatedly were a sense of being overwhelmed, unsure, helpless, confused, or frustrated. The feelings described were that of unease, fury and disappointment. Participants described that they were under-trained and ill-equipped.

CHAPTER 5: DISCUSSION

A common theme in Section 1 of this researcher's study (Perceived Knowledge and Training) is the fact that most participants – from the basic BAC level to the highly qualified EM Registrar level – did not feel as confident or well-equipped as they could be to deal with cases of child abuse. The higher percentage of correct answers among EM registrars for this section can be attributed to the fact that these personnel do receive formal training on the handling of legalities such as completing the J88 form and reporting abuse, while the other qualification levels are taught *only* that abuse must be reported. Despite ALS, ILS and BLS levels being taught that abuse should be reported, many respondents were mistaken about who the abuse should be reported to; they were also not aware of the protection that the law offered them when reporting suspected abuse in good faith – many were under the impression that they could be sued for reporting suspected abuse that, in actual fact, turned out to be a false alarm. A result of this misconception and fear could be that a higher number of cases go unreported and child patients fail to receive the help that they need beyond the mere treatment of physical injuries. These patients also remain in situations in which they continue to be injured – psychologically, emotionally and physically.

The majority of participants felt fairly comfortable dealing with the more practical aspects of treatment but opined that they were not trained to deal with the psychological aspects of the interaction. Their feelings of preparedness to deal with the psychological aspects of abuse generated the highest negative response among participants for Section 1. They also felt inadequately trained when it came to knowing what to say and how to respond to the child when abuse was suspected, evident in, or disclosed by the child. This included knowing how to physically interact with the child and how to understand the psychological and emotional space of the child at the time of treatment.

The lack of confidence among all four groups with regard to their training resulted in some EMS personnel feeling helpless, inadequate, frustrated and disappointed after having attended calls involving child abuse. Since over 90% of all respondents agreed that one's

response to a disclosure can have a long-term effect on the victim, yet more than half of them felt inadequately trained to know what to say and how to respond, proper training on this aspect of treatment is imperative if we hope to minimise any long-term negative effects on the child as a result of improper or poor handling of a disclosure at the time of treatment.

A South Africa study conducted on the EMS personnel in the private ambulance service focused on how the needs of personnel could influence management practices. The researcher determined that one of the four major requirements of personnel was the need to feel competent. If the EMS personnel believed that they were hindered by a lack of training after a call, they experienced elevated stress levels[75]. Training focused on equipment, new protocols and alternative techniques, with an absence of role-play. Situations involving the treatment of mentally disturbed patients, difficult children or suicidal patients were not addressed. Psychological training, which should be included in the EMS curriculum, is essential when counselling patients.

The majority of EM registrars understand the importance of completing the J88 form. Of the 30 doctors who participated in the study, 15 (50%) strongly agreed that they were able to complete the J88 form correctly, while 13 (43%) agreed and a further two (6%) disagreed. Since the South African judicial system admits three types of evidence – written, oral or medical – an incorrect or incomplete document may be rejected on a technicality. This will delay the completion of the docket to be used by the prosecuting team in the event that the case goes to court. This can delay the hearing and, in turn, the healing process for the child.

Since the EM registrar is often the first person to treat the assaulted victim, his or her observations may be crucial. Although the J88 form is time-consuming to complete and puts EM registrars under further duress, it is the only document that facilitates the patient's access to justice.

The J88 form corroborates the victim's testimony with the doctor's findings and is used by the prosecutor to determine whether or not to pursue a case. It is also essential that

information recorded on the J88 form is reflected in all other documentation by EMS personnel. The importance of correctly completing the J88 cannot be emphasized enough.

Adequate training in correctly observing the mental state of the child is therefore paramount. For instance, a child could be in such severe shock that they appear very calm whilst disclosing. A doctor who is not astute or well-trained enough to realize this, may assume that the child is not traumatized; this can very well dictate their attitude towards the child in their interaction.

However, completing documentation that asks for the mental state of a subject is not always an easy task. A study has been conducted on trained professionals in Sweden where the law states that the school system record all aspects of the child's health and development. This law has not been without its problems: Trained nurses at schools were found to be reluctant to comment on, or document, mental wellbeing since they concluded that it was not a clear process. Conversely, physical findings were meticulously documented. The main reason cited for the lack of mental health documentation was ethical considerations regarding observations of mental health and fears that the child would be further stigmatised.

Furthermore, the majority of the nurses who participated in the study found the documentation process to be problematic since they were unsure of what to document about the mental wellbeing of their patients[76]. One can conclude from this study that the untrained EMS professional is even more disadvantaged in this respect.

5.1 Knowing what to say to a child when abuse is suspected or disclosed

In the absence of positive and appropriate support from EMS personnel for the child in the initial stages of the interaction, there is little chance that further disclosure will take place[77]. It is further unlikely that the patient will provide an accurate history of events prior to the

injury. According to this researcher's findings, EMS personnel generally displayed low levels of confidence when it came to knowing what to say or how to interact with the child.

Knowing how to respond to an actual disclosure generated even less confidence. Advanced Life Support paramedics displayed the lowest confidence levels, despite being older with many more years' experience on the job, while Intermediate and Basic Life Support personnel displayed surprisingly high levels of confidence considering their youth and inexperience. This could be attributed to the fact that Advanced Life Support paramedics, due to their extensive road experience, have been exposed to more child abuse cases and realise just how difficult and traumatic they can be. It could also be hypothesised here that the ALS are the back up to the BLS and ILS crews and this could place additional pressure on them. In addition to this, they often do not have the luxury of time on their side in which to call a social worker, and so much of the interaction with the child is left to them.

Basic Life Support personnel showed the second-highest levels of confidence after EM registrars and in a couple of instances scored even higher than the EM Registrars (*Question 6: When a child DISCLOSES physical or sexual abuse during treatment, you feel adequately trained to know what to say and how to respond to the child* and *Question 8: Your training has adequately prepared you to deal with the psychological/emotional aspects of child abuse when treating a patient*). It could be hypothesised that this surprisingly high level of confidence is due to the fact that the BLS group is more than likely enthusiastic and ready to apply all that they have learnt and due to having limited practical on-the-road experience not yet undergone the harsh reality of attending to an actual call.

It is important that the EMS professional is able to complete treatment when a child discloses abuse. Overall, 39.2% of participants agreed that some sort of list was available to report child abuse while 43% of doctors agreed that a contact list was available in their workplace. These statistics illustrate a lack of support for EMS professionals who would have to independently source contact numbers in already pressurised situations. The interaction of the EMS personnel does not end with the treatment of the injuries. EMS personnel need

to be in possession of a contact list of recommended support services at all times so that families and caregivers can access professional help.

5.2 Sexual assault versus rape

EMS personnel must be educated about current legislation pertaining to sexual assault. For example, *Question 11: Inserting an object into a vagina is called indecent assault*. According to the newly-amended definitions of rape, this does not constitute indecent assault: It is rape. Almost all of the respondents (97%) believed that inserting an object into the vagina of a non-consenting female is known as sexual assault, including 28 out of the 30 EM registrars questioned.

The definition of rape is as follows: "Rape**:** Any person (A) who unlawfully and intentionally commits an act of sexual penetration with a complainant (B) without the consent of B is guilty of the offence of rape."[78] This new law is gender-neutral, recognising that any form of non-consensual penetration constitutes rape. These statistics clearly indicate that the participants are unfamiliar with the new law.

In South Africa, sex with a minor is a Schedule Six offence that carries an automatic life sentence in the absence of compelling, extenuating circumstances. Should a victim be required to go to court, the necessary paperwork must be completed correctly. Training is required to ensure that the paperwork conforms to the court's requirements if there is to be any hope of a trial and, better still, a successful conviction.

During 2001, the Medical Research Council released a document pertaining to the best post-rape practices, aimed at rape care units and those medical professionals examining patients. An intensive investigation by government departments ensued, focusing on the documentation, treatment and legal recourse of rape victims.

The investigation revealed the shortfalls and lack of co-operation of the medico-legal clinics and sectors in Gauteng. These included the "incompetent documentation of medico-legal documents such as the J88 form; inadequate training; insensitive treatment of rape

survivors; and lack of clear protocols across the provinces". The revision of training pertaining to the medico-legal documentation was identified as a priority[79]. It is clear, however, that the first responders are not receiving adequate training on how victims should be treated. The disclosure process is commonly perceived to be divorced from the initial treatment – something that should be left to "the experts". The training is concentrated around recognising physical signs and symptoms of child abuse, the different types of abuse, and how to treat associated injuries.

CHAPTER 6: LIMITATIONS

The main limitation in this study was that the second part of the survey questionnaire featured a binary response option with clearly right and wrong answers regarding legal, administrative or emergency care aspects of child abuse, thus showing actual knowledge of the participants. Being Yes/No questions, participants may have randomly guessed the answers leading to a skewed representation of actual knowledge.

Modifying the ordinal response scale in Section 1 to a binary response scale has added a further limitation as it eliminates a gradient over which respondents could express their perceived knowledge and comfort level.

Another limitation was the fact that many participants may have perceived themselves to be adequately trained and prepared as well as demonstrating that they have sufficient knowledge in areas relating to legal, administrative and emergency care aspects of child abuse but they may not be applying their knowledge in practice. This was not part of the study but came up as a concern or recommendation for further research.

Furthermore language may have created a barrier in the participants' ability to understand and interpret the questions. For example Question 13 was framed negatively*: When Child Abuse is suspected rather than confirmed, you are under no obligation to report it.* Participants may have responded by thinking yes you must report it, and indicating strongly agree, but are actually strongly agreeing to the negative statement that you are under no obligation to report it.

Finally, the call for respondents was not made to all actively operational EMS professionals within the Western Cape metropolitan area. With fewer than 10% of active professionals participating, the results are limited and do not reflect the perceived and actual knowledge of all EMS professionals.

CHAPTER 7: RECOMMENDATIONS

It is imperative that EMS personnel have a full understanding of how to facilitate disclosure from a medical perspective as well as from the point of view of the victim. Disclosure is a multi-faceted process and its layers and evolutionary process must be fully understood in order to ensure a disclosure that benefits the victim and facilitates the prosecution of the perpetrator(s). A disclosure should ideally include the victim asking for help and naming the perpetrator involved in the crime committed against him or her.

A clear protocol is recommended for all medical personnel dealing with the disclosure of child abuse. Empirical literature confirms that early disclosure and how this is handled accelerates the child's healing process.

Based on this study the researcher recommends that:

- An expansion to the current syllabus for EMS personnel and MMED students on child abuse is developed.
- EMS personnel and doctors are taught to better identify the non-visible signs of child abuse and understand the pervasive nature of CSA[80].
- EMS personnel and doctors are taught how to deal with the psycho-emotional aspects of the interaction when a child discloses abuse.
- EMS personnel and doctors understand the process of disclosure and non-disclosure and the factors that might inhibit a disclosure.
- The implementation of a set of guidelines for EMS personnel and doctors to follow when dealing with disclosure so as to increase their confidence levels and provide a point of reference they can revert back to.
- EMS personnel and doctors are taught to view disclosure as an integral part of the call and not a separate phenomenon to be dealt with by other auxiliary agencies in the child protection arena.

- EMS personnel and doctors attend workshops in which revised laws are reviewed; these could be offered as part of continuing professional development (CPD) training for CPD points.
- Simulated interactions of disclosure form part of basic and on-going training for all cadres of emergency care worker[81].

CHAPTER 8: CONCLUSION

The findings of this study highlight the need to expand training and knowledge in the area of child abuse for emergency-care providers within the Western Cape Metropole.

Emergency-care providers may also benefit from a set of guidelines to assist them when dealing with a child who discloses abuse. A proposed protocol for dealing with disclosure is attached (Appendix G) and may be used by EMS personnel. Further research evaluating guideline application, usefulness and effectiveness is recommended.

REFERENCES

1 UNICEF. Home page of UNICEF South Africa. [Internet]. 2011 [cited 2014 Jun 5]. Available from: http://www.unicef.org.za/articles/every-statistic-tells-a-story

2 Newton AW, Vandeven AM. The Role of the Medical Provider in the Evaluation of Sexually Abused Children and Adolescents. Journal of Child Sexual Abuse. 2010;19(6):669–686.

3 Castro, J. Live Science Earliest Case of Child Abuse Discovered in Egyptian Cemetery. [Internet]. 2013 [cited 2013 Sep 14]. Available from: http://www.livescience.com/34738-egypt-cemetery-reveals-child-abuse.html

4 Caffey J. The Whiplash Shaken Infant Syndrome: Manual Shaking by the Extremities With Whiplash-Induced Intracranial and Intraocular Bleedings, Linked With Residual Permanent Brain Damage and Mental Retardation. Paediatrics. 1974;54(4):396–403.

5 Olds LD, Henderson RC, Chamberlin, Tatebaum R. Preventing Child Abuse and Neglect: A Randomised Trial of Nurse Home Visitation. Paediatrics. 1986;65–78

6 Allagia R. Many Ways of Telling: Expending conceptualisations of child sexual abuse disclosure. Child Abuse & Neglect. 2004;28(11):1213–1227.

7 Kogan MS. Disclosing unwanted sexual experiences: Results from a national sample of adolescent women. Child Abuse & Neglect. 2004;28(11):147–165.

8 Ermertcan AT, Ertan P. Skin manifestations of child abuse. Indian Journal of Dermatology, Venereology and Leprology. 2010;76:317–26.

9 O'Donnell M, Nassar N, Leonard H, Mathews R, Patterson Y, Stanley F. Monitoring Child Abuse and Neglect at a Population Level: Patterns of hospital admissions for maltreatment and assault. International Journal of Child Abuse and Neglect. 2010;34(11):823–832.

10 Janssen TL, Van Dijk M, Al Malki I, Van as S. Management of Physical Child Abuse in South Africa: Literature review and children's hospital data analysis. Paediatrics & International Child Health. 2013;33(4):216–227.

11 Putnam-Horstein E, Cleves MA, Licht R, Needell R. Risk of Fatal Injury in Young Children Following Abuse Allegations: Evidence From a Prospective, Population-Based Study. American Journal of Public Health. 2013;103(10):39–44.

12 Lampbrecht L, Wild A, Labuschagne T. Gauteng Department of Education: Guidelines and Procedure for Dealing with Suspected and Confirmed Cases of Child Abuse. Gauteng Department of Education and Teddy Bear Clinic. 2008;6–9.

13 Twaite JA, Rodriguez-Srednicki O. Understanding and Reporting Child Abuse: Legal and Psychological Perspectives: Part two: Emotional abuse. Journal of Psychiatry and Law. 2004;443–458.

14 Keith-Oakes J. Emotional Abuse: Destruction of the spirit and the sense of self. Clearing House. 1990;64(1):31.

15 Vevers S. Piecing the abuse jigsaw together. Community Care. 2008;(1707):16–17.

16 Kohl PL, Kagotho JN, Dixon D. Parenting Practices among Depressed Mothers in the Child Welfare System. Social Work Research. 2011;35(4):215–225.

17 Mallen A. It’s Like Piecing Together Small Pieces of a Puzzle. Difficulties in Reporting Abuse and Neglect of Disabled Children to the Social Services. Journal of Scandinavian Studies in Criminology & Crime Prevention. 2011;12(1):45–62.

18 Goodman-Brown TB, Edelstein RS, Goodman GS et al. Why children tell: a model of children’s disclosure of sexual abuse. Child Abuse Neglect. 2003;May; 27(5):525–40.

19 South African Police Services. South African Police Services Annual Statistics Report [Internet]. 2014 [cited 2014 Dec 15]. Available from: http://www.saps.gov.za

http://www.saps.gov.za/resource_centre/publications/statistics/crimestats/2014/crime_stats.php

20 Dawes A, Ward CL. Levels, trends, and determinants of child maltreatment in the Western Cape Province. In: Marindo R, editor. The State of Population in the Western Cape Province. Cape Town: HSRC Press; 2008.

21 Browne A, Finkelhor D. Impact of sexual abuse: A review of research. Psychological Bulletin. 1986;(1):66–77.

22 Makoane M, Waria A, Bower C, Ward C, Loffel J, Dawes A. South Africa country report on the situation on prevention of child maltreatment study. Geneva. Human Sciences Research Council; 2009.

23 Westcott H, Page M. Cross-Examination, Sexual Abuse and Child Witness Identity. Child Abuse Review. 2002;11(3):137–152.

24 Mokoae M, Warria A, Bower C, Ward C, Loffel J, Dawes A. South Africa Country report on the situation on prevention of child maltreatment study. Cape Town: HSRC WHO. 2009;30.

25 Wyatt G, Peters S. Issues in the definition of child sexual abuse in prevalence research. Child Abuse and Neglect. The International Journal. 1986;10(2):231–240.

26 Langness LL. Child abuse and neglect: Cross-cultural perspectives. Los Angeles. University of California Press; 1981.

27 South African Government. Government Gazette. Criminal Law (Sexual Offences and Related Matters) Amendment Act, Act No. 32 of 2007. Pretoria: Government Printers; 2007.

28 Mahomed I, Olivier P, Mokgoro Initial, Gauntlett J, Mojapelo P et al. Sexual offences against children. Pretoria: South African Law Commission. 1997;(Paper No.10):29.

29 Whittle H, Haqmilton-Giachritsis C, Beech A, Collings G. A review of young people's vulnerabilities to online grooming, aggression & violent behaviour. 2013;18(1):135–146.

30 Mitchel KJ, Jones LM, Finkelhor D. Internet-facilitated commercial sexual exploitation of children. Sexual Abuse: A Journal of Research and Treatment. 2011;23:43–71.

31 Mitchel KJ, Jones LM, Finkelhor D. Internet-facilitated commercial sexual exploitation of children. Sexual Abuse: A Journal of Research and Treatment. 2011;23:43–71.

32 Aiken M, Moran L, Berry MJ. Child abuse material and the internet: Cyber psychology of online child-related sex offending. [Internet]. 2012:1 [cited 2013 October]. Available from: http://www.interpol.int/Crime-areas/Crimes-against-children/Internet-crimes

33 Von Weiler J, Haardt-Becker A, Schulte S. Care and treatment of child victims of child pornographic exploitation (CPE) in Germany. Journal of Sexual Aggression. 2010 July;16(2):211–222.

34 Barret B. The impact of childhood sexual abuse and other forms of childhood adversity on adulthood parenting. Journal of Child Sexual Abuse. 2009;18(5):489–512.

35 Lacelle C, Herbert M, Lavoie F, Vitaro F, Trembaly R. Child Sexual Abuse and Women's Sexual Health: The Contribution of CSA Severity and Exposure to Multiple Forms of Childhood Victimisation. Journal of Child Sexual Abuse. 2012;21:571–592.

36 Easton S. Masculine norms, disclosure, and childhood adversities predict long-term mental distress among men with histories of child sexual abuse. Child Abuse & Neglect. 2014 Feb;38(2):243–251.

37 Ullman SE, Filipas HH. Gender differences in social reactions to abuse disclosures, post-abuse coping, and PTSD of child sexual abuse survivors. Child Abuse & Neglect. 2005;29:767–782.

38 Leung, Phil W S; Wong, William C W; Tang, Catherine S K; Lee, Albert. *Family Practice.* Apr 2011, Vol. 28 Issue 2, p195–201.

39 McElvaney R, Greene S, Hogan D. To Tell or Not to Tell? Factors Influencing Young People's Informal Disclosures of Child Sexual Abuse. Journal of Interpersonal Violence. 2014;29(5):928–947.

40 Sorensen T, Snow B. How Children Tell: The Process of Disclosure in Child Sexual Abuse. Child Welfare. 1991;70(1):7–14.

41 Collings SJ, Griffiths S, Kumalo M. Patterns of disclosure in child sexual abuse. South African Journal of Psychology. 2005;35(2):270–285.

42 Goodman-Brown TB, Edelstein RS, Goodman GS et al. Why children tell: a model of children's disclosure of sexual abuse. Child Abuse & Neglect. 2003 May;27(5):525–40.

43 Minnie L. Death and dying: what are the psychological consequences to the emergency care personnel in the Cape Town metropole services [MSc thesis]. UCT; 2013.

44 Bunting L, Lazenbutt A, Wallace I. Information Sharing and Reporting Systems in the UK and Ireland: Professional Barriers to Reporting Child Maltreatment Concerns. Child Abuse Review. 2010;19:195.

45 Anderst JJ, Dowd D. Comparative needs in child abuse education and resources: perceptions from three medical specialties. Medical Education Online. 2010;15(1):1–8.

46 Schols MW, Ruiter C, Ory FG. How do public child healthcare professionals and primary school teachers identify and handle child abuse cases? A qualitative study. BMC Public Health. 2013;13(1):1–16.

47 Plichta SB, Vandercar-Burdin T, Odor RK, Reams S, Zhang Y. The emergency department and victims of sexual violence: an assessment of preparedness to help. Journal of Health & Human Services Administration. 2006;29(3):285–308.

48 Widom CS, Czaja SJ, Dutton MA. Childhood victimisation and lifetime revictimisation. Child Abuse & Neglect. 2008;32(8):785–796.

49 Currie J, Widom CS. Long-Term Consequences of Child Abuse and Neglect on Adult Economic Well-Being. Child Maltreatment. 2011;16(3):233–233.

50 Goodman-Brown TB, Edelstein RS, Goodman GSet al. Why children tell: a model of children's disclosure of sexual abuse. Child Abuse & Neglect. 2003 May;27(5):525–40.

51 Katz L, Hershkovitz L, Malloy LL et al. Non-verbal behaviour of children who disclose or do not disclose child abuse in investigative interviews. Child Abuse & Neglect. 2012 Jan;36(1):12–20.

52 Tong E, Gillespie M. Childhood sexual abuse: Help make it 'Safe to Say'. British Journal of Nursing. 2011;20(9):555–558.

53 Palmer SE, Brown RA, Rae-Grant NI. Responding to Children's Disclosure of Familial Abuse: What Survivors Tell Us. Child Welfare. 1999;78(2):259–282.

54 Palmer SE, Brown RA, Rae-Grant NI. Responding to Children's Disclosure of Familial Abuse: What Survivors Tell Us. Child Welfare. 1999;78(2):259–282.

55 Jensen TK, Gulbrandsen W, Mossige S et al. Reporting possible sexual abuse: A qualitative study on children's perspectives and the context for disclosure. Child Abuse & Neglect. 2005;29(12):1395–1413.

56 Pipe ME, Lamb ME, Orbach Y et al. Child sexual abuse: Disclosure, delay and denial. Applied Cognitive Psychology. 2008;22:1318–1323.

57 Hershkowitz I. Facilitating disclosures of abuse by reluctant children: A test of the revised niche protocol. European Psychiatry. 2013;28:1–11.

58 Sorensen T, Snow B. How Children Tell: The Process of Disclosure in Child Sexual Abuse. Child Welfare. 1991;70(1):7–14.

59 Lampbrecht L, Wild A, Labuschagne T. Guidelines and procedure for dealing with suspected and confirmed cases of child abuse. 2008;6–9.

60 Allagia RL. Disclosing the trauma of child sexual abuse: a gender analysis. Journal of Loss & Trauma. 2011;10(5):453–470.

61 Allagia R, Mishna F. Self Psychology and Male Child Sexual Abuse: Healing Relational Betrayal. Clinical Social Work Journal. 2014;42(1):41–48.

62 Allagia R, Mishna F. Self Psychology and Male Child Sexual Abuse: Healing Relational Betrayal. Clinical Social Work Journal. 2014;42(1):41–48.

63 O'Leary, Coohey C, Easton SD. The Effect of Severe Child Sexual Abuse and Disclosure on Mental Health during Adulthood. Journal of Child Sexual Abuse. 2010;19(3):275–289.

64 Hughes T. The neglect of children and culture: responding to child maltreatment with cultural competence and a review of child abuse and culture: working with diverse families. Family Court Review. 2006;44(3):501–510.

65 O'Leary, Coohey C, Easton SD. The Effect of Severe Child Sexual Abuse and Disclosure on Mental Health during Adulthood. Journal of Child Sexual Abuse. 2010;19(3):275–289.

66 Fung JJ, Lau AS. Punitive discipline and child behaviour problems in Chinese-American immigrant families: The moderating effects of indigenous child-rearing ideologies. International Journal of Behavioural Development. 2009;33(6):520–530.

67 Maphosa C, Shumba A. Educators' disciplinary capabilities after the banning of corporal punishment in South African schools. South African Journal of Education. 2013;30(3):387–399.

68 Fung JJ, Lau AS. Punitive discipline and child behaviour problems in Chinese-American immigrant families: The moderating effects of indigenous child-rearing ideologies. International Journal of Behavioural Development. 2009;33(6):520–530.

69 Solomon, CR, Serres, F. Effects of parental verbal aggression on children's self-esteem and school marks. Child Abuse & Neglect. 1999;23(4):339–351.

70 Summit RC. The child sexual abuse accommodation syndrome. Child Abuse & Neglect. 2012;7(2):177–193.

71 Walker-Descartes I, Sealy YM, Laraque D, Rojas M. Caregiver perceptions of sexual abuse and its effect on management after a disclosure. Child Abuse & Neglect. 2012;35(6):437–447.

72 Jobe A, Gorin S. If kids don't feel safe they don't do anything: Young people's views on seeking and receiving help from Children's Social Care Services in England. Child & Family Social Work. 2013;18(4):429–438.

73 Hershkowitz I. Facilitating disclosures of abuse by reluctant children: a test of the revised niche protocol. European Psychiatry. 2013;28:1–11.

74 Van Der Zelm CT. Protecting the innocent: Children's Act 38 of 2005 and Customary Law in South Africa Conflicts, consequences and possible solutions. Emory International Law Review. 2008;22(2):891–926.

75 Kriek HC. An investigation into the needs of emergency medical workers and how these could inform management practices [MA thesis]. Unisa; 2009.

76 Clausson EN, Kohler K, Berg A. Ethical challenges for school nurses in documenting schoolchildren's health. Nursing Ethics. 2008;15(1):40–47.

77 Sorensen T, Snow B. How Children Tell: The Process of Disclosure in Child Sexual Abuse. Child Welfare. 1991;70(1):7–14.

78 South African Government. Government Gazette. Criminal Law (Sexual Offences and Related Matters) Amendment Act, Act No. 32 of 2007. Pretoria: Government Printers; 2007.

79 Suffla S, Seedat M, Nascimiento A. Evaluation of medico-implications for the development of best practices in after care of rape survivors. MRC-Unisa, Crime violence and injury lead programme. 2005;5:1–12.

80 Walker-Descartes I, Sealy IM, Baroque D, Rojas M. Caregiver perceptions of sexual abuse and its effect on management after a disclosure. Child Abuse & Neglect. 2011;35(6):437–447.

81 Lexton A, Smith M, Olufemi D, Poole G. Taking a risk and playing it safe: The use of actors in interagency in child protection training. Child Abuse Review. 2005; 14:195–206.

APPENDICES

Appendix A: BLS and ILS syllabus from Western Cape Metro EMS College

7.4.12 CRISIS INTERVENTION

CONTENTS

7.4.12.1 ABUSED CHILD

– Psychologically abused child.

– Emotional.

– Physically abused child.

– Nutritionally and sexually abused child.

– AEA: Legal obligation (refer to point 7.1.1)

7.4.12.2 SUDDEN INFANT DEATH SYNDROME

7.4.12.3 SPECIAL SITUATIONS

– The dying – death counselling, care of the dying.

– The suicidal.

– Domestic incidents/violent.

– Rape.

7.4.12.4 SOCIOLOGY AND PSYCHOLOGY (Care of the care givers)

– Stress and coping strategies.

– Values and norms.

– Mental health – mental illness.

– Transactional analyses.

– Defence mechanisms.

– Conflict management.

– Leadership.

– Communication skills.

OBJECTIVES

CHILD ABUSE

– Recognition, professional interventions, control of own emotions, support child and parents, clinical picture and emergency care of victims of the abused child:
  - Physical
  - Mental
  - Nutritional
  - Sexual.
– Understand the role of the AEA in the above situations and apply legislation appropriately.

SUDDEN INFANT DEATH SYNDROME

– Recognise sudden infant death syndrome (SIDS) and the management of the infant and the parent.

Appendix B: ALS syllabus from Western Cape Metro EMS College

Only the sections of the syllabus pertaining to the treatment of paediatrics and child abuse has been provided below. The full ALS curriculum can be found on https://app.box.com/s/a4jk3fxpl2cu4hoz0m2k.

CRITICAL CARE ASSISTANT

CURRICULUM 2010

MODULE 15. PAEDIATRICS

– Assessment of a traumatised child.

– Trauma in the child and the emergency care of the victim.

– Management of foreign body in the orifice.

– Taking of a paediatric history, primary and secondary survey.

– Respiratory tract diseases –

Coryza

Sinusitis

Tonsillitis/pharyngitis

Asthma

Otitis externa and media

– Congenital heart diseases.

– Recognition, treatment and supplementation for marasmus and kwasiorkor.

– Other nutritional deficiencies with reference to recognition, treatment and preventative education.

– Assessment and management of the following infant and child emergencies –

Shock

Heart failure

Coma

Status epilepticus

Burns

Trauma

– Approved paediatric drug protocols, pharmacological actions, side-effects, routes of administration and dosage.

– Various forms of child abuse and neglect.

– Acute Epiglottitis, bronchiolitis and laryngotracheal bronchitis.

– Paediatric respiratory tract diseases.

– Psychological support and management in paediatrics –

Principles

Reasons

– Vasovagal reflex in paediatrics –

Dangers

Triggering in infants and children

– The aetiology, pathophysiology clinical picture, management and complications of –

Hyperpyrexia/fever

Croup

Epiglottitis

Meningitis

Encephalitis

Gastro-enteritis, diarrhoea and vomiting –

: Pathological

: Idiopathic

: Malnutrition

Dehydration, including –

: Fluid and electrolyte replacement

: UNESCO universal formula

: Colic

: Hyaline membrane disease

: Hypothermia

: Hypoxia

: Hypoglycaemia

: Croup

: Epiglottitis

– Recognition and management of the high risk baby.

– Recognition, clinical picture and emergency care of poisoning in children.

– Evaluation of fluid loss in neonates, infants and children and how to calculate

replacement requirements.

– Common surgical problems –

Pyloric stenosis – diagnosis/treatment

Acute painful limb/joint – diagnosis/treatment

Burns – treatment in hospital and referral criteria

Congenital diseases surgery – timing thereof and referral

Malignancies – types

Atrial/anal/oesophageal

REVISION:

WEEK 18

MODULE 28. SOCIOLOGY & PSYCHOLOGY

– Stress symptoms, effects (long and short terms), and management thereof.

– Understand –

Critical incident stress – definition, stressors, symptoms, acute and cumulative response

Acute stress

Delayed stress

Cumulative stress

Post-traumatic stress syndrome.

– Motivation values and interests, human needs and the motivation for personal behaviour.

– Conflict management.

– Mental health, mental illness.

– Leadership with reference to –

Types/classifications

Characteristics

Supervisor

Attributes of a good leader

Application of leadership functions as a CCA.

– Communication skills.

– Family disorganisation –

The concepts of disorganisation

Types of disorganised families

Reasons for family disorganisation

Divorce, the effects on children and the couple, grounds for divorce

Child abuse – physical, emotional and sexual

– Alcoholism with reference to –

Types of drinker

The threshold theory of alcoholism

Appendix C: FCEM(SA) syllabus from the Colleges of Medicine of South Africa (CMSA)

Only the sections of the syllabus pertaining to the treatment of paediatrics and child abuse has been provided below. The full FCEM (Emergency Medicine speciality degree for doctors) curriculum can be found on https://app.box.com/s/ewh343rhtlr1c0les8ij

FCEM(SA) PAGE 20

1.23 Psychosocial disorders:

- Emergency assessment and stabilisation of behavioural disorders
- Psychotropic medications
- Anorexia nervosa and bulimia nervosa
- Hysteria and panic disorder
- Conversion reactions
- Crisis intervention
- Emergency evaluation of prisoner and substance abuse patients
- Physician well-being
- Debriefing techniques

1.24 Abuse and assault:

- Spectrum of child abuse and neglect
- Male and female sexual assault
- Domestic violence
- Abuse in the elderly and impaired/disabled
- The violent patient
- Post-traumatic stress management

Appendix D: Questionnaire

Questionnaire for Emergency Medical Services (EMS) personnel to determine perceived and actual knowledge on the subject of child abuse

Thank you for agreeing to participate in this survey.

The goal of the survey is to determine the levels of perceived and actual knowledge of Emergency Medical Services (EMS) personnel when treating children who have been abused. It is also to determine how well-equipped EMS personnel feel when dealing with child abuse, disclosure of abuse by the child, and whether they feel they would benefit from formal training in this subject area.

Certain questions must be completed by doctors only (indicated in brackets before the question).

This questionnaire will take approximately 15 minutes to complete.

Qualification

Current position or occupation

Number of years' experience treating patients

Age

Section One

The aim of Section One is to determine the perceived level of knowledge and training of Emergency Medical Services personnel when attending to cases of child abuse.

1. When a child presents with obvious signs of abuse, you feel adequately trained to know what is legally required of you.

- ☐ Strongly agree
- ☐ Agree
- ☐ Disagree
- ☐ Strongly disagree

2. When a child presents with obvious signs of abuse, you feel adequately trained to complete the necessary legal documentation.

- ☐ Strongly agree
- ☐ Agree
- ☐ Disagree
- ☐ Strongly disagree

3. When a child presents with obvious signs of abuse, you feel adequately trained to know what to say to the child.

- ☐ Strongly agree
- ☐ Agree
- ☐ Disagree
- ☐ Strongly disagree

4. When a child presents with obvious signs of abuse, you feel adequately trained to know how to physically interact with the child.

- ☐ Strongly agree
- ☐ Agree
- ☐ Disagree
- ☐ Strongly disagree

5. When a child presents with obvious signs of abuse, you feel adequately trained to understand the emotional space of the child.

- ☐ Strongly agree
- ☐ Agree
- ☐ Disagree
- ☐ Strongly disagree

6. When a child DISCLOSES physical or sexual abuse during treatment, you feel adequately trained to know what to say and how to respond to the child.

- ☐ Strongly agree
- ☐ Agree
- ☐ Disagree
- ☐ Strongly disagree

7. Your training has adequately prepared you to deal with the practical aspects of child abuse when treating a patient.

- [ ] Strongly agree
- [ ] Agree
- [ ] Disagree
- [ ] Strongly disagree

8. Your training has adequately prepared you to deal with the psychological / emotional aspects of child abuse when treating a patient.

- [ ] Strongly agree
- [ ] Agree
- [ ] Disagree
- [ ] Strongly disagree

9. (Doctors only) You can correctly complete all sections of the J88 form required by the South African Police.

- [ ] Strongly agree
- [ ] Agree
- [ ] Disagree
- [ ] Strongly disagree

Section Two

The aim of Section Two is to determine the actual level of knowledge and training of Emergency Medical Services personnel when attending to cases of child abuse.

10. According to the law, a male can be raped.

- [ ] Yes
- [ ] No

11. According to the law, inserting an object into the vagina of an unconsenting female is known as sexual assault.

- [ ] Yes
- [ ] No

12. You can refuse to obey a subpoena on the grounds of protecting doctor-patient confidentiality.

- [ ] Yes
- [ ] No

13. If child abuse is just suspected rather than obvious or confirmed, you are under no obligation to report it.

- [ ] Yes
- [ ] No

14. If you are called to court as a witness you are allowed to ask to read your original statement you gave to the police before testifying.

- [ ] Yes
- [ ] No

15. (Doctors only) As a medical professional examining the patient and filling out the J88 form, you are not required to fill in the mental state of the victim at the time of examination.

- [ ] Yes
- [ ] No

16. A female patient twelve years of age can consent to an abortion.

- [ ] Yes
- [ ] No

17. A 14-year-old child can consent to a medical procedure.

- [ ] Yes
- [ ] No

18. If you allow a rape victim to urinate before the vaginal vault is swabbed for DNA evidence, it will obliterate the evidence.

- [ ] Yes
- [ ] No

19. Examination of a sexually abused child should always be done under anaesthetic.

- [ ] Yes
- [ ] No

20. Shaken Baby Syndrome occurs in children mostly under six months of age.

- [ ] Yes
- [ ] No

21. Sex with a minor, without compelling and substantial circumstances, carries a life sentence.

- [ ] Yes
- [ ] No

22. Medical evidence can be submitted in court when, on examination of the victim, circumstances suggest abuse but do not confirm abuse.

- [ ] Yes
- [ ] No

23. Children who testify in court always testify in a special courtroom.

- [ ] Yes
- [ ] No

24. If child abuse is suspected, it is advisable to question the child further about the abuse and who the perpetrator is.

- [ ] Yes
- [ ] No

25. When a perpetrator is acquitted in a court of law, it means he/she is innocent.

- [ ] Yes
- [ ] No

26. You can be held liable, or sued by the defendent, if you report a case of suspected abuse and the court rules that it was not.

- [ ] Yes
- [ ] No

27. The parent or caregiver may, at their discretion, drop the charges against the perpetrator once a docket has been opened.

- [ ] Yes
- [ ] No

28. Children younger than 8 years have poor judgement and generally disclosures of abuse cannot be taken seriously.

- [ ] Yes
- [ ] No

29. When a child starts disclosing abuse to you during treatment, your reaction to the disclosure can have a long-term effect on the child's feelings of self-esteem and well-being.

- [ ] Yes
- [ ] No

30. When children below the ages of 6 or 7 disclose, the disclosures tend to be deliberate rather than spontaneous.

- [ ] Yes
- [ ] No

31. It is important to understand why children don't disclose abuse.

- [ ] Yes
- [ ] No

32. If you come across a case of child abuse, you need to report it to your station commander/hospital superintendent.

- [ ] Yes
- [ ] No

33. You have seen a list of contact numbers and/or resources for reporting cases of child abuse displayed in your workplace.

- [ ] Yes
- [ ] No

34. If you have ever treated a case of sexual or physical child abuse, please explain how you handled the case. Please also describe how it made you feel.

Appendix E: Ethics Approval Letter from the Research Ethics Committee

UNIVERSITY OF CAPE TOWN

Faculty of Health Sciences
Human Research Ethics Committee
Room E52-24 Groote Schuur Hospital Old Main Building
Observatory 7925
Telephone [021] 406 6338 • **Facsimile** [021] 406 6411
e-mail: lamees.emjedi@uct.ac.za

13 December 2012

HREC REF: 654/2012

Ms B Dessena
Emergency Medicine
J Floor
OMB

Dear Ms Dessena

PROJECT TITLE: A STUDY TO DETERMINE PERCEIVED AND ACTUAL KNOWLEDGE OF CAPE TOWN EMERGENCY MEDICAL SERVICE PERSONNEL WITH REGARD TO THE CARE OF VICTIMS OF CHILD ABUSE

Thank you for submitting your study to the Faculty of Health Sciences Human Research Ethics Committee.

It is a pleasure to inform you that the Ethics Committee has **formally approved** the above-mentioned study.

Approval is granted until 15 December 2013.

Please submit to the HREC a Progress Report Form if the study continues beyond the approval period. Please submit a Closure Report Form on completion of the study. (Forms can be found on our website: http://www.health.uct.ac.za/research/humanethics/forms/

Please note that the ongoing ethical conduct of the study remains the responsibility of the principal investigator.

Please quote the REC. REF in all your correspondence.

Yours sincerely

PROFESSOR MARC BLOCKMAN
CHAIRPERSON, FHS human research ethics committee

Federal Wide Assurance Number: FWA00001637.
Institutional Review Board (IRB) number: IRB00001938

Lemjedi

Appendix F: J88 form

G.P.-S. 01/02 J 88 (81/805259)

REPORT BY AUTHORISED MEDICAL PRACTITIONER ON THE COMPLETION OF A MEDICO-LEGAL EXAMINATION 1

To be completed in legible handwriting and signed on every page

A. DEMOGRAPHIC INFORMATION

1. Police station:	2. CAS No.:	3. Investigating officer: Name and number:	4. Time ☐☐:☐☐ Day ☐☐ Month ☐☐ Year ☐☐☐☐

5. Name of medical practitioner:
6. Registered qualifications:
7. Phone number:
8. Fax number:
9. Place of examination:

10. Physical practice address or stamp:

11. Full names of person examined: 12. Sex: M ☐ F ☐ 13. Date of birth/apparent age:

B. GENERAL HISTORY

1. Revelant medical history and medication:

C. GENERAL EXAMINATION

1. Condition of clothing:

2. Height (cm):	3. Mass:	4. General body build:

5. Clinical findings: In every case the nature, position and extent of the abrasion, wound or other injury must be described and noted together with its probable date and manner of causation. The position of all injuries and wounds must also be noted on the sketches.

6. Mental health and emotional status:

7. Clinical evidence of drugs or alcohol:

8. CONCLUSIONS

Signature of medical practitioner

D. HISTORY IN CASE OF ALLEGED SEXUAL OFFENCE [2]

1. Age of menarche ☐☐ 2. Number of pregnancies ☐☐ 3. Number of deliveries ☐☐ 4. Duration of pregnancy (if applicable) ☐☐ weeks

5. Contraception (indicate with X): Yes ☐ No ☐
6. Method and last date of application/ingestion:
7. First date of last menstruation:
8. Duration of period ☐☐ 9. Duration of cycle ☐☐

10. Date and time of last intercourse with consent:
11. Number of consensual sexual partners during last 7 days:
12. Condoms: Yes ☐ No ☐

13. Since the alleged offence took place, has the person (indicate with X): bathed ☐ washed ☐ douched ☐ showered ☐ urinated ☐ changed clothing ☐

E. GYNAECOLOGICAL EXAMINATION (State clinical findings)

1. Breast development: Tanner stage 1–5 ☐
2. Pubic hair: Tanner stage 1–5 ☐
3. Mons pubis:
4. Clitoris:
5. Frenulum of clitoris:
6. Urethral orifice:
7. Para-urethral folds:
8. Labia majora:
9. Labia minora:
10. Posterior fourchette: scarring: bleeding: tears: increased friability:
11. Fossa navicularis:
12. Hymen: configuration:
13. Opening diameter (mm): Transverse ☐☐ Vertical ☐☐
14. Swelling:
15. Bumps:
16. Clefts:
17. Fresh tears (position):
18. Synechiae:
19. Bruising:
20. Vagina: Number of fingers admitted: bleeding: tears: discharge:
21. Cervix: erosion: discharge: bleeding: other:
22. Perineum:

F. SAMPLES TAKEN FOR INVESTIGATION

1. Forensic specimens taken: Urine sample for pregnancy test: Positive ☐ Negative ☐ Seal number of Evidence Collection Kit:
2. Specimens handed to: Name: Rank and Force number: Signature:
3. CONCLUSIONS

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Signature of medical practitioner

G. ANAL EXAMINATION (State clinical findings) 3

SKIN SURROUNDING THE ORIFICE

1. Hygiene:
2. Pigmentation:
3. Fissures/cracks:
4. Abrasions:
5. Scars:
6. Swelling/thickening:
7. Redness/erythema:
8. Bruising/haematoma:
9. Tags:

ORIFICE

10. Tears/fissures:
11. Swelling/thickening of rim (tyre sign):
12. Funnelling:
13. Reflex dilatation:
14. Shortening/eversion of anal canal:
15. Cupping:
16. Twitchiness/winking:
17. Discharge:

DIGITAL EXAMINATION

18. Presence of hard faeces in rectum:
19. Laxity (pressure on anal orifice):
20. Thickening of anal verge:
21. Tone (sphincter grip):

22. CONCLUSIONS

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H. MALE GENITALIA

1. Genital development: Tanner stage 1–5 ☐
2. Glans:
3. Testes:
4. Ulceration:
5. Presence of faeces:
6. Pubic hair: Tanner stage 1–5: ☐
7. Shaft:
8. Epididymus:
9. Penile discharge:
10. Circumcision:
11. Prepuce and frenulum:
12. Scrotum:
13. Vas deferens:
14. Smegma:
15. Urethral orifice:

16. CONCLUSIONS

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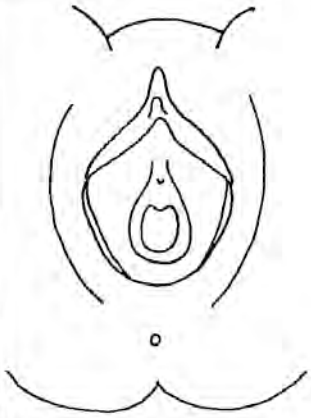
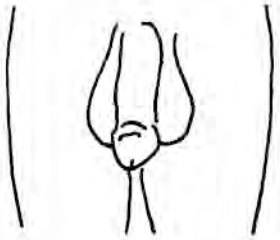
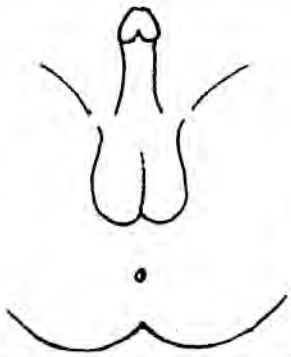
SCHEMATIC DRAWING OF FINDINGS

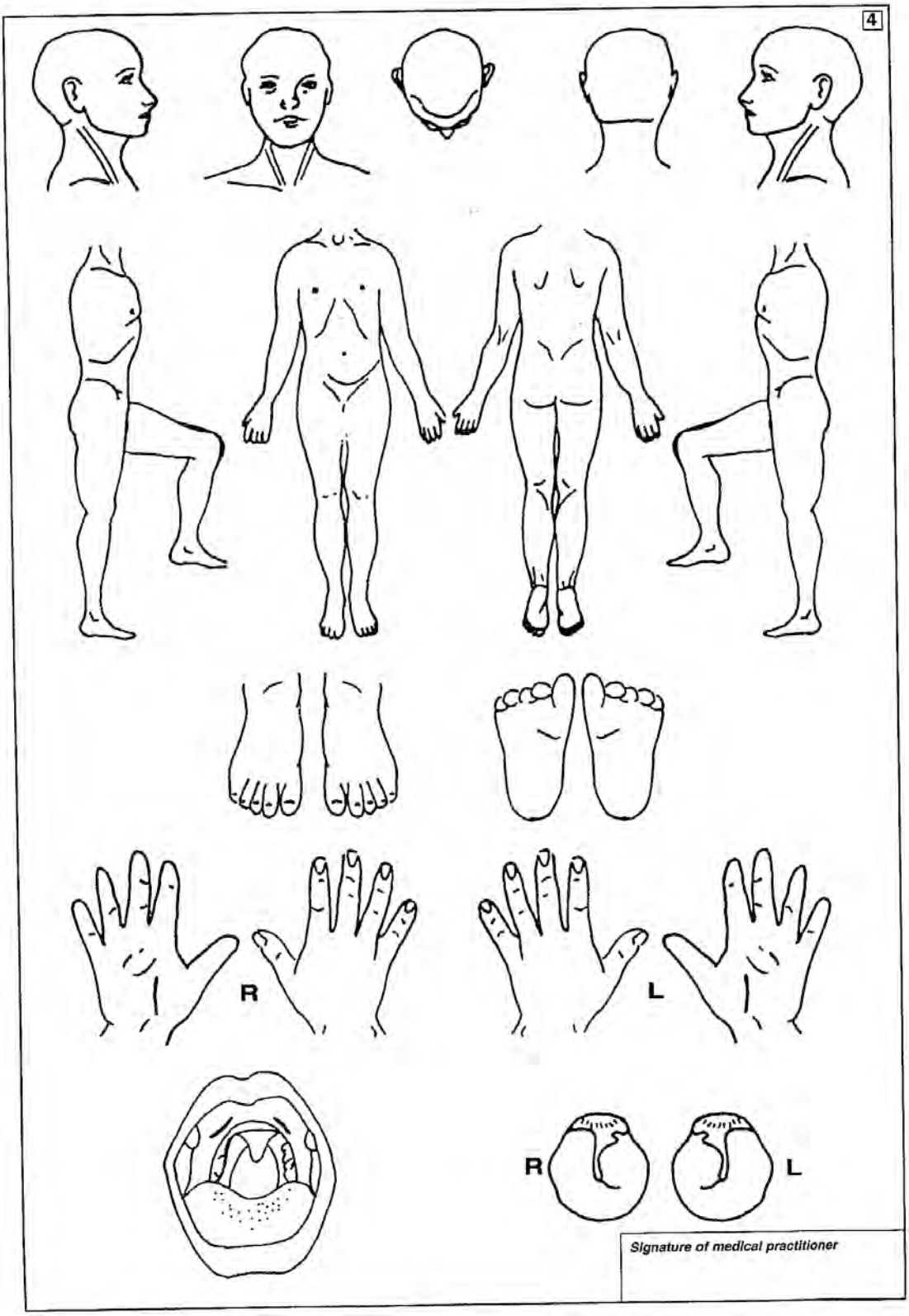






Signature of medical practitioner

4



Signature of medical practitioner

Appendix G: Proposed protocol for dealing with disclosure

Physical interaction during disclosure

Behaviour towards the child:

- Take a deep breath and remain calm.
- Come down to the child's level, maintain eye contact, and give the child your undivided attention (ignore external distractions, including your cellphone).
- Maintain an open posture towards the child.
- Keep your tone friendly; use short sentences and easy to understand words.
- Make sure that the child understands you; get an interpreter, if needed.
- Do not overreact with anger, judgement or disgust.

What you should say from a legal and ethical standpoint:

- Some secrets are bad and they make us feel sad and angry.
- When we share bad secrets we can get help.
- If you are being hurt we must tell other adults because the law says we must protect children from people who hurt them. You can decide which member or friend you want to tell, but we must also tell the police and/or a social worker.
- Telling others may be hard but it is to try and help you.

Important phrases to use with the child after disclosure:

- Thank you for telling me, I know it was not easy.
- I want you to know how brave you are.
- You have done the right thing to tell me.
- I want you to know that I believe you.
- I want you to know that whatever has happened to you is not your fault.
- I want you to know that it is not because of who you are that this bad thing has happened to you.
- If you want me to help you to tell another adult your story, I will be with you. You will not be alone.

- Whatever happens from now on, I will explain everything to you.
- I need to make notes of what you tell me because your story is very important (**take verbatim disclosure notes** for legal proceedings; do NOT substitute the child's words or terms with your words, no matter how disjointed they may sound).

What not to do

- Do not threaten to hurt the abuser; most abusers are known to the victim. The child may love the abuser even though they do not love the actions of the abuser.
- Do not hand out your phone number.
- Do not touch the child unnecessarily; ask permission to take off their clothes if the examination requires you to do so. Show them that you respect their little bodies.
- Do not accuse anyone of the abuse and do not ask the child if it was a particular person.
- Do not pry information from the child.
- Do not promise the child anything you cannot keep.
- Do not allow the child to shower or bath in case a rape kit has to be obtained.

Important to remember:

- Questions asked can **only** be: Who, What, When, Where and How.
- Respect the child's silence.
- Take note of the child's interactions with the caregivers.
- If you have reasonable suspicion that abuse has taken place and you report it, you cannot be sued by any caregiver, even if it turns out that you were wrong. You are reporting in good faith. Remember, you are obligated to report abuse, both confirmed and suspected.
- Try to have a witness with you at all times throughout the call.
- If the child is in immediate danger and a caregiver refuses you access to remove the child, do not argue – contact the S.A.P. straight away.

Take meticulous notes, even if the patient is a priority 3 (green patient). Include your observations regarding the child's surroundings, how they live, the attitudes of the caregivers, or anything else you may notice.